Portfolio Volume 1: Major Research Project

The experience of clinical psychologists enacting compassionate leadership in health and social care settings.

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Abstract

Background: The leadership experiences of clinical psychologists remain markedly under-researched in comparison to medical and nursing professions. Post-pandemic, the health and social care landscape has rapidly evolved, with clinical psychologists operating across increasingly diverse environments, demanding new skills. While compassionate leadership has gained prominence within NHS policy discourse and emerging acknowledgement within clinical psychology professional guidelines, its lived experience among clinical psychologists, who hold leadership as a core professional function, remains largely unexamined. This study explores how clinical psychologists *enact* compassionate leadership, and how this is shaped by the systems in which they work.

Method: Eight clinical psychologists working across a range of health and social care settings who self-identified as closely aligned with compassionate leadership following a reflective exercise, were recruited via purposive and snowball sampling. Semi-structured interviews were conducted, and data were analysed using Interpretative Phenomenological Analysis.

Results: Six group experiential themes were identified: Self-compassion; Fostering psychological safety; A "*courageous dance*"; Deep empathy- attunement and embodiment; Misunderstood- '"*fluffy*", "*wafty",* and unboundaried; and Navigating uncompassionate systems.

Discussion: The enactment of compassionate leadership is explored in relation to literature including the three-systems model of emotion regulation (Gilbert, 2009) , the 'good enough mother' theory (Winnicott, 1953), secure base leadership (Kohlrieser, 2012), reflective practice (Schön, 1983), the dual-process model of courage (Chowkase et al., 2024), role congruity theory (Eagly & Karau, 2002), mindfulness, cultural safety, and ecological systems

theory (Bronfenbrenner, 1979). The findings explore how experiences of enacting compassionate leadership are informed by characteristics of gender, age, ethnicity, and by relational conditions such as psychological safety, trust, discrimination, support, and inclusive practice.

Conclusion: This study shows that compassionate leadership among clinical psychologists is characterised by self-compassion, fostering psychological safety, courage, deep empathy, being misunderstood, and negotiation with systemic constraints. Compassionate leadership is shaped by individuals' identities, organisational cultures and access to resources. The findings imply that sustaining compassionate leadership requires both individual capacities and structural supports rather than reliance on personal resilience alone.

Recommendations: Ensure regular, protected reflective spaces (e.g. Schwartz Rounds, peer supervision) are maintained, introduce compassion-focused supervision, embed mindfulness-based self-compassion and compassionate leadership workshops. Strengthen psychological safety through visible leadership modelling, anti-blame cultures, culturally sensitive supervision training, and measures that support inclusive practice. Finally, to align and include compassionate leadership competencies in local and professional body leadership frameworks.

Keywords: Compassionate leadership, Clinical psychologist, Psychological safety, Interpretative phenomenological analysis, health and social care

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[1] This note has been added throughout to make clear spaces have intentionally been left blank for layout consistency/ readability.

1.0 Introduction

1.1 Chapter Overview

This chapter introduces the research position, and the epistemological stance adopted in this thesis. It introduces a compassion-based model alongside the broader context of healthcare leadership, mental healthcare, and clinical psychology. By examining policy, guidance and outcomes regarding leadership across these domains, this chapter aims to orientate the reader to the contemporary leadership context in mental healthcare and clinical psychology. It also highlights the relative paucity of primary leadership research within clinical psychology compared to the wider mental health and healthcare professions. The focus is primarily on the UK's National Health Service (NHS), a core part of the health and social care[2] (H&SC) sector, though international evidence is occasionally drawn upon due to its relevance and comparability with UK healthcare roles and responsibilities.

1.2 Research position and reflexivity

My lens within this study of compassionate leadership is influenced by my personal, professional, and cultural background. In qualitative research, it is crucial to acknowledge how such positioning influences one's interpretations and engagement with data (Berger, 2015). Given my pre-existing connection with this topic, it is important to practice reflexivity throughout this research and gain awareness of how my personal experiences, values, and identity shape my approach to the topic, including how I interact with participants and interpret the data (Braun & Clarke, 2019). To mitigate biases, I kept a reflective diary (Appendix 1), and engaged in reflexive discussions with the research team to remain open to the diverse perspectives and experiences of others. The focus of this thesis is primarily on the UK's

[2] Section 1.4 (page 19) introduces the H&SC context.

National Health Service (NHS), a core part of the health and social care[3] (H&SC) sector which I have experience in. International evidence is occasionally drawn upon due to its relevance and comparability with UK healthcare roles and responsibilities.

1.2.1 Professional Background and Experience

My professional journey in mental and physical healthcare inspired my interest in compassionate leadership. Having completed the NHS Graduate Management Training Scheme (GMTS), I gained hands-on experience in making difficult decisions and advising leaders across all levels through a city-wide H&SC system. I was involved in developing person-centred policies, recruitment, training, staff health and well-being, planning and operationalising COVID-19 vaccine centres, during a volatile time. I also earned a Postgraduate Certificate in Healthcare Leadership, which deepened my theoretical understanding and enacting leadership. The experiences, both in receiving and enacting leadership, provided me with professional insights into the key role that compassion plays in contemporary leadership. Within a pressurised health and social system, I have observed that compassionate leadership can be linked to positive relational and organisational outcomes, while its absence may be accompanied by difficulties such as burnout, low morale, and strained team dynamics (NHS England, 2020a).

1.2.2 Cultural and Religious Influence

My cultural and religious upbringing as a Hindu informs my perspective on compassion. In Hinduism[4], compassion forms one of the Yamas (ethical rules) which is discussed in the Rigveda, one of the four sacred texts in Hinduism. Compassion is embedded

[3] Section 1.4 (page 19) introduces the H&SC context.
[4] Hinduism is diverse and decentralised, encompassing a range of philosophical schools, devotional practices, and regional variations. As such, my interpretation may reflect this nuance.

in the moral and ethical framework of Hinduism and is referred to in a nuanced way with words such as and 'Daya' and 'Karuṇā'. These terms refer to the enactment of compassion by sympathising with one's suffering, but also actively alleviating the suffering of other people, animals, and plants whenever and however possible. This context shaped messages within my upbringing of how 'to be' around others, though not necessarily how one receives compassion. Compassion within this belief system, is not an abstract or theoretical concept, but a lived principle that guides interactions and has real-world implications for well-being and ethical leadership.

1.2.3 Gender and Professional Identity

As a male researcher in the mental health field, I recognise my exploration of compassion intersects with gender norms and expectations. Compassion is stereotypically associated with femininity, particularly in professional settings (Gartzia & Van Engen, 2012; Villiers, 2019). This stereotype can lead to the marginalisation of compassionate practices among male leaders or even the perception that such practices are at odds with traditional notions of male leadership, which colonially emphasise authority, control, and detachment (Pujolràs-Noguer, 2019). I am hopeful my global majority identity coupled with being a male completing a clinical psychology doctorate, can begin to challenge these stereotypes.

1.3 Epistemological stance

This study is grounded in a critical realist epistemology that distinguishes between the 'real' world and the 'observable' world. The critical realist approach is characterised by ontological realism, which asserts that there are real structures and mechanisms that exist independently of our knowledge of them (Niiniluoto, 2002) combined with epistemological relativism, which recognises that our understanding of these structures is mediated by social

contexts (Vincent & O'Mahoney, 2018). Critical realism therefore posits that knowledge is contextual and there is no universal truth, therefore knowledge is shaped by our context.

The topic of compassionate leadership is well-suited to a critical realist position because it involves complex interactions between real, but often intangible, structures and mechanisms (such as organisational culture, policies, power dynamics) and the subjective experiences of individuals (such as perceptions, motivations, thoughts and emotions). Thus the critical realist position would acknowledge the existence of intangible structures even if not directly perceived by the individual, and seek to understand their influence on compassionate leadership behaviour and outcomes. Consequently, the study hopes to generate tangible and meaningful recommendations for the development of compassionate leadership practice within clinical psychology.

1.4 Leadership: A brief overview of leadership scholarship development

Leadership is a multifaceted ever evolving concept shaped by varying context, culture, and history (West & Bailey, 2023, pp. 29-53). Leadership scholarship encompasses a wide range of theories, approaches, and models, which are also referred to as styles when a leader engages in activities related to the practice of leadership. T*heories* provide explanatory frameworks for understanding how leadership works. *Approaches* are broader orientations or value-based perspectives that guide leadership practice. *Models* typically present structured, practice-oriented tools or representations designed for application in specific contexts. Together, these elements represent the evolving discourse and application of leadership (Northouse, 2021).

In the 1840s, philosopher Thomas Carlyle's *Great Man Theory*, suggested leadership is an innate talent, not a learnable skill (Spector, 2016). This early conceptualisation was

inherently gender-biased, assuming leadership qualities were exclusive to men. Early 20th century *Trait Theory of Leadership* evolved from this, focusing on specific traits or personality characteristics that effective leaders possess. For example, intelligence, confidence, and decisiveness were thought to be indicators of leadership potential (Northouse, 2021). By the mid to late 20th century, the military and political context allowed for *authoritarian leadership* to gained traction in leadership discourse. This style on centralised decision-making, where leaders maintain control, making decisions independently, prioritising hierarchy, efficiency, and order (Pizzolitto et al., 2022). With emphasis on discipline and rapid-decision making, it was viewed as effective in structured, high-stakes settings.

While early leadership research was historically influential, the research has been criticised for privileging white male leaders as the norm, and excluding diverse perspectives and experiences (Wiborg, 2022). Early leadership research also lacks empirical support, minimise contributions of members and stifle innovation, particularly in collaborative or creative contexts (Ola, 2017). Moreover, their overemphasis on individual traits has been faulted for overlooking situational and relational dynamics now recognised as important to effective leadership (Nawaz & Khan, 2016). Contemporary socioeconomic, political and human rights challenges increasingly view top-down leadership as outdated and misaligned with modern ethical and social imperatives. Modern leadership is framed as a relational process, shaped by authenticity, collaboration, and social justice.

Table 1 introduces leadership approaches that prioritise empathy, ethical practice, and shared power. While these vary in terminology and scope, they converge around values closely aligned with compassionate leadership (Evans, 2022). However, compassionate leadership extends these approaches by placing greater emphasis on intentional, value-driven action.

Table 1

Overview of contemporary leadership styles

Leadership approach	**Key features**	**Relevance to Health and Social Care**	**Link to compassionate leadership**
Servant leadership (Greenleaf, 1970/2015)	• Puts others' needs first. • Ethical, empathetic, collaborative. • Stewardship and empowerment	• Crucial in healthcare in promoting trust, empathy and collaboration (Eva et al., 2019. • Linked to better staff engagement, satisfaction, and retention, which ultimately improve care quality and patient satisfaction (West & Markiewicz, 2016). Altruism linked to reduced burnout (Wu et al., 2022)	Shares focus on empathy and values, though compassionate leadership extends this by actively engaging with distress and relational context (De Zulueta, 2015)
Transformational leadership (Burns, 1978; Bass, 1985) *note this is a theory and model, but included due to ethical and social relevance, and alignment with compassionate leadership.	• Inspires and motivates people to follow. • Aligns personal and organisational goals. • Stimulates innovation and collaboration through vision, ethical role modelling, and fostering trust (Bass & Rigio, 2006).	Popularity surged in healthcare due to its link to improving patient outcomes, safety, enhancing team cohesion, and empowerment (Boamah, 2018; Ystaas et al., 2023).	Compassionate leadership operationalises inspiration and empowerment by aiming to challenge power differentials and focusing on a grounded, relational approach within the context of healthcare and psychological practice (Pattison & Corser, 2022).
Authentic leadership (George, 2003)	• Transparent, self-aware, values-driven (Avolio & Gardner, 2005) • Integrity, and accountability in leadership (George, 2003)	• Gained prominence after incidents like the Mid Staffordshire failing, the Winterbourne View scandal, and the Lampard inquiry into mental health deaths • Builds psychological safety and trust (West et al., 2015)	• Scandals highlighted a need to rebuild trust in healthcare systems. • Transparency can be challenging in large systems having confidentiality policies; compassionate leadership focuses on attunement to context and relational nuance (Döner, 2018, p.73).

		• Supports emotional resilience and staff wellbeing in high pressure settings (Raso, 2019).	
Leadership style	**Key features**	**Relevance to Health and Social Care**	**Link to compassionate leadership**
Inclusive leadership (Shore et al., 2018)	• build a culture of trust and respect • Values diverse voices. • Builds equity, anti-racism, representation. • Extends authentic leadership into diversity space	Crucial in NHS due to staff/patient diversity and systemic inequities such as pay gaps, discrimination (NHS England, 2024a)	Shares ethical foundations and equity focus though compassionate leadership responds more directly to the emotional and relational consequences of inequality (West et al., 2020; De Zulueta, 2015)

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1.5 Leadership and The Health & Social Care (H&SC) context

The UK H&SC system is a comprehensive arrangement delivered primarily through the NHS and local authorities, but also involving services commissioned by integrated care boards including third sector, private, and independent providers. The NHS, established in 1948 provides universal healthcare free at the point of use, funded primarily through taxation. Local authorities manage social care services, including residential care, home support, and community health services, as mandated by the Care Act 2014. This legislation modernised adult social care law, emphasising personalised care and preventative support.

System Leadership is increasingly framed through relational and value-driven lenses. NHS England (2018) defines leadership as 'the ability and capacity to lead and influence others, by means of personal attributes and/ or behaviours, to achieve a common goal' (NHS England, 2018, p. 4). This highlights the interpersonal nature of effective leadership. The health and care professions council (HCPC) is the regulator of health and care professions in the UK, and state that leadership can be demonstrated across any level, and 'means acting as a role model and displaying the core aspects of professionalism, such as effective communication, team working, and being able to reflect on your own practice' (HCPC, 2021). This aligns with contemporary leadership theories that prioritise relational dynamics over hierarchical authority. Similarly, the Care Quality Commission (CQC), the independent regulator for H&SC in England, embeds compassionate leadership within its *Well-Led* assessment domain, evaluating leadership visibility, inclusivity, and supportiveness (CQC, 2024). This expectation was magnified during the COVID-19 pandemic, which underscored the importance of compassionate leadership in sustaining morale, tackling organisational stress, and promoting equitable, high-quality care (Halliwell, 2023). Collectively, these perspectives

reflect a sector-wide shift towards dynamic, human-centred leadership approaches such as transformational, servant, and compassionate leadership.

The pandemic highlighted strengths, but also exposed longstanding H&SC challenges, including workforce shortages, underfunding, and health disparities, particularly affecting global majority and vulnerable populations (Robertson et al., 2021; Williams, 2024). Following this, the Health and Care Act 2022 introduced Integrated Care Systems (ICS) to foster greater collaboration across services, improve population health outcomes, reduce inequalities, and build resilience against future crises (Charles, 2022). Through this experience, inclusive and compassionate leadership is increasingly recognised as critical to navigating complexity and underpinning meaningful change across the H&SC landscape.

1.5.1 Covid-19: a catalyst for Compassionate leadership

Prior to the World Health Organization declaring COVID-19 a global pandemic on 11 March 2020, the UK's health system was already strained from a decade of austerity, staff shortages amplified by Brexit, an ageing population, and growing waiting lists (Propper et al., 2020; British Medical Association, 2022). While these operational under such conditions might suggest efficiency, they also make the system more vulnerable in crisis. Limited pre-pandemic data regarding mental health services suggests a lack of focus on mental health services (National Audit Office, 2022; NHS England, 2019c; Propper et al., 2020), with available data revealing shortcomings in areas such as low female engagement with perinatal mental health services, underperformance in IAPT access and recovery rates for BAME[5] populations, and insufficient adherence to psychosis service guidelines (NHS England, 2019c).

[5] BAME stands for Black, Asian, and Minority Ethnic. While commonly used in UK health and social care policy and publications, it has been widely critiqued for oversimplifying diverse identities and experiences. The term "global majority" is increasingly preferred for its emphasis on shared experiences and global representation.

Covid-19 was the largest public health crisis in a century. Healthcare leaders in the UK faced an unprecedented evolving crisis, in an already under-resourced healthcare system. Healthcare leaders were required to make complex decisions under uncertainty, balancing patient care with staff well-being and safety (Martínez-Sanz et al., 2020). Large-scale initiatives demanded urgent, innovative problem-solving that tested both systemic and human resilience (Webb et al., 2020). Leaders had to maintain clear communication and coordinate hybrid teams to meet multiple operational priorities while sustaining team cohesion (West et al., 2020). Pressures were immense, as hospital beds filled rapidly, and staffing shortages exacerbated by sickness and isolation measures meant leaders were forced to work with reduced staffing and less capacity in unfamiliar situations (Propper et al., 2020). Within social care settings, populations such as older adults and those with learning disabilities were at greater risk of harm, adding further leadership pressure to ensure vulnerable groups were not disadvantaged (Comas-Herrera et al, 2020; Nyashanu et al, 2020).

Leaders during the pandemic faced significant challenges in addressing the emotional and psychological strain on healthcare workers stretched beyond their limits, working prolonged hours in unfamiliar high-pressure and high mortality environments, with limited mental health support (San Juan et al., 2020). Burnout, already a pervasive issue before the pandemic, worsened during COVID-19, with health and social care professionals reporting clinically significant increases in burnout (Gemine et al., 2021; Giebel et al., 2021). Leaders were required to offer emotional support and maintain morale amid these unprecedented pressures (Östergård et al., 2023). Healthcare workers often entered their workplaces experiencing emotional distress, including post-traumatic stress, fear, guilt, anxiety, hopelessness, interpersonal conflict, perceived inequality, and organisational mistrust (Hollingsworth, 2024; Koontalay et al., 2021; NHS Employers, 2022).

1.5.2 Mental health service pressures

Working in mental health settings carries significant emotional and psychological demands. Mental health professionals often develop close, empathetic relationships with patients, gaining deep insight into their struggles, which naturally requires compassionate care. However, the sustained requirement to demonstrate empathy and compassion, particularly under high caseload pressures, can lead to compassion fatigue, a form of mental exhaustion arising from the chronic stress of caregiving, described as the "cost of caring" (Figley & Ludick, 2017). Compassion fatigue reduces emotional resilience and the capacity to provide effective care, with global prevalence in mental health settings ranging between 24% and 60%, with protective measures being inclusive leadership, self-care practices, and supervision (Marshman, 2022; Singh et al., 2020).

A related phenomenon is burnout, characterised by emotional exhaustion, impersonal responsiveness, and diminished professional efficacy (Maslach & Leiter, 2016). Staff in community mental health teams (CMHTs) are particularly vulnerable to burnout compared to those in specialised teams such as crisis or assertive outreach services (O'Connor et al., 2018).

An associated concept, moral injury, refers to the psychological distress that arises when an individual is involved in making decisions, witnesses, or fails to prevent events that violate their deeply held moral or ethical values (Williamson et al, 2023). Moral injury is gaining increasing research attention, where it has been suggested healthcare services have an ethical imperative to encourage a culture where self-care and wellbeing promotion are celebrated, with environments needing to support and rebuild the trust lost during the pandemic (Hollingsworth, 2024).

Attention from leaders is required, as 38 % of NHS staff found work emotionally exhausting, 34% felt burnt out, and 43% of staff reporting felt worn out at the end of their shift (NHS Employers, 2022; NHS Providers, 2024). The largest reason for staff sickness was "anxiety/stress/depression/other psychiatric illness", which accounted for 26% of staff absences in June 2024 (NHS Digital, 2024). Worryingly, 17,000 mental health staff (12%) left the workforce in 2021–22, compared to approximately 14,000 annually before the pandemic (National Audit Office, 2023). The proportion leaving due to work-life balance concerns rose sharply from four percent in 2012/13 to 14% in 2021–22, while the percentage of working days lost due to psychiatric reasons doubled over the same period (Public Accounts Committee, 2023).

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1.6 What is compassionate leadership?

The leadership response during and post-pandemic has emerged as a critical area for reflection and action (NHS Confederation, 2022a). Expecting healthcare staff to continue working as they were during the pandemic would not be sustainable or compassionate (NHS Confederation, 2022a, p20). During the pandemic, NHS leaders were encouraged to model compassion and promote connection, with compassionate leadership seen as the most supportive way to deal with overwhelming and frightening experiences (Bailey & West, 2020). Compassionate leadership has been referred to as an approach (Bailey & West, 2022a; Evans, 2022, Ramachandran et al, 2023), though it is also acknowledged to still be developing a research base.

One way to conceptualise how humans respond to the pressurised healthcare environment highlighted in the prior section, is through the three-system affect regulation model, rooted in neurobiological and evolutionary theory that outlines how human affect is regulated by three systems (Gilbert, 2009):

- The drive system: focused on achievement and reward.
- The threat system: triggered by fear and protection.
- The soothing system: associated with connection, safety, and compassion.

Figure 1 applies the three-systems model to the reported challenges of crisis healthcare working.

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Figure 1

Three-system model applied to working in crisis and prolonged pressure (Adapted from Gilbert, 2009)

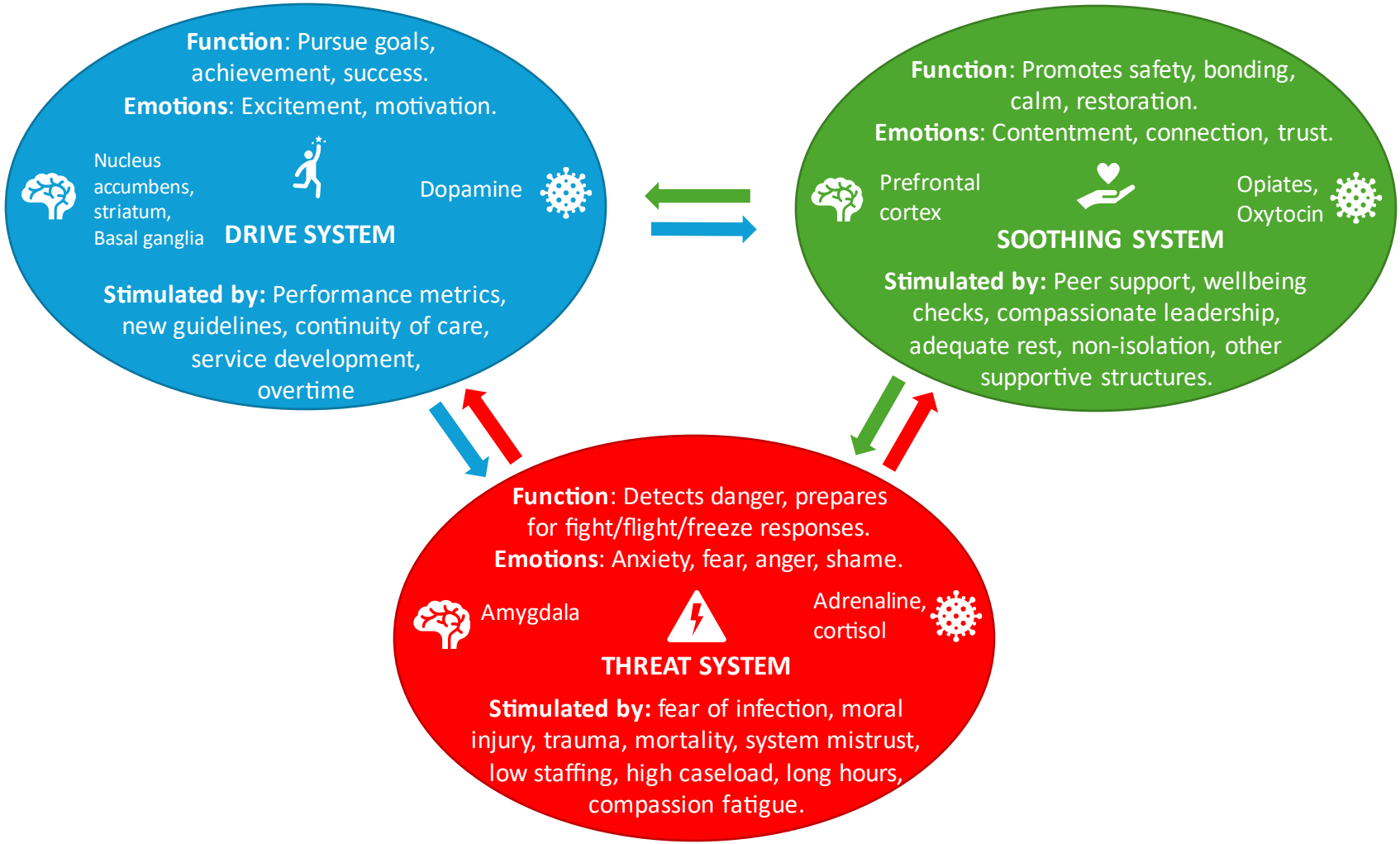

Figure 1 illustrates how the three systems may interact and regulate one another. During the pandemic, it is likely that the threat system was overactive, with healthcare staff potentially experiencing chronic fear of infection, high mortality rates, and moral injury due to making ethically complex decisions under pressure. These factors were compounded by the long hours and continued demands placed on staff. Simultaneously, it seemed the drive system was also overactive, as staff appeared to be working relentlessly to meet targets, implement new protocols, and maintain continuity of care. Organisational change and a performance-driven culture likely intensified feelings of pressure. For instance, maintaining service delivery while managing depleted teams and adapting to constantly changing guidance likely placed leaders and clinicians in unsustainable patterns of overwork.

In contrast, it is suggested that the soothing system, associated with rest, connection, and psychological safety, may have been largely under activated. With overwhelming demands taking priority, time for reflection, peer support, and connection may have been neglected. An imbalance through the overactivation of the threat and drive systems coupled with under activation of the soothing system could potentially have contributed to emotional distress, including burnout and compassion fatigue. The pandemic appeared to have highlighted the need for 'a new approach to leadership based on the core value of compassion', with compassionate leadership requiring 'huge courage, resilience, and belief' at every level within the healthcare system (Bailey & West, 2022b).

Compassionate leadership is known to be based on four behaviours: attending, understanding, empathising, and helping (Atkins & Parker, 2012). A scoping review exploring compassionate leadership in healthcare found that no clear or consistent theory existed was specific to compassionate leadership, suggesting that further research is needed (Evans,

2022). West (2021) recaps the four behaviours associated with compassionate leadership in a healthcare context, summarised in Figure 2.

Figure 2

Behaviours of a compassionate leader (Adapted from West, 2021)

These behaviours help create psychologically safe environments such that staff feel valued, cared for, and respected, which helps them reach their potential at work (Bailey & West, 2022a). This contributes to a healthier, happier workforce with improved patient outcomes (West, 2021). However, compassionate leadership has been found lacking in healthcare settings and demanded by healthcare professionals, who also reported absences in leader empathy, support, understanding, empathy and appreciation (Salminen-Tuomaala & Seppälä, 2022).

Coinciding and influenced by the pandemic, the NHS established a several strategic initiatives embedding compassionate leadership. These include the Long Term Plan (LTP, NHS England, 2019a), the People Plan (NHS England, 2020a), the Long Term Workforce Plan (LTWP,

NHS England, 2023b), and the Workforce Race Equality Standards (WRES, NHS England, 2024a). Table 2 provides a summary of these initiatives and how they link to compassionate leadership. Despite this compassionate shift, they could all be criticised for lacking detail regarding the operationalisation compassionate leadership.

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Table 2

Summary of NHS Strategies and Compassionate Leadership Integration

Policy/ Initiative	Purpose and Focus	Approach to compassionate leadership (CL)	Challenges and reflections
NHS Long Term Plan (LTP) (NHS England, 2019a)	10-year strategy to improve integrated care, population health, digital innovation, financial stability, primary care, cancer treatment, and mental health services.	• Compassion is embedded in the cultural vision; calls for empathetic and diverse leadership (p. 79). • Promote compassion among staff that parallels compassion to patients. • Outlines actions such as diversifying leadership pipelines and introducing measures to support senior leaders (Charles et al., 2019).	• Compassion is emphasised conceptually, but lacks detail on implementation mechanisms. • Consultation already begun on a new plan 5 years in, due to being made redundant due to evolving landscape.
NHS People Plan (NHS England, 2020a)	• Foster a culture of compassion and inclusion across the NHS workforce (p. 6). • Enhancing recruitment, retention, diversity, and staff well-being.	• CL explicitly identified as essential to address systemic inequalities (p. 10), provide support in crises (p. 16), and compassionate communication among staff (p. 20). • The People Promise: A pledge to a "compassionate and inclusive" and "safe and healthy" workplace (p. 14). • Advocates free mental health support and resilience training to address the psychological demands of healthcare work (p. 18).	• Lacks clear implementation strategies and sufficient funding to fill entrenched workforce gaps (Bailey, 2020). • Resilience training was not well received. • Highlights the tension between aspirational leadership frameworks and the practicalities of leadership change.
NHS Long Term Workforce Plan (LTWP), (NHS England, 2023b)	Address criticisms of the People Plan by proposing long-term workforce sustainability through growth, retention,	• Builds on culture of compassion and inclusion with a focus on equity for BAME and disabled staff (p. 34). • Aligns well-being and patient care outcomes (p. 63). • Embeds compassion into training (p. 87)	More explicit than prior plans, but success dependent on sustained implementation and evaluation which is ongoing.

	productivity, and technology integration.		
Policy/ Initiative	**Purpose and Focus**	• **Approach to compassionate leadership**	• **Challenges and reflections**
Workforce Race Equality Standard (WRES**),** (NHS England, 2024a)	Annual monitoring of representation, pay gaps, and staff experience.	• Promotes compassion through equity, voice, and psychological safety. • links inclusive leadership to patient outcomes and productivity. • Some measurable progress: Ethnic board diversity has doubled; slightly reduced BAME disciplinary rates compared to white colleagues, and 9% increase in BAME workforce.	• 63% of BAME staff report not looking forward to attending work (Ross, 2024). • Highlights the complexity of translating compassionate leadership principles into tangible, widespread cultural change.
NHS 10 year health plan (Department of health and social care, 2024)	• Moving care from hospitals to communities • Making better use of technology • Focussing on preventing sickness, not just treating it	• Still under consultation • Informed by the Darzi report, focusing on compassionate care.	• The Darzi report stated the "NHS is in critical condition, but vital signs are strong" (Darzi, 2024) Thus action is needed now. • The situation may be different by the time the plan is published making it redundant. • More of the same.

1.6.1 Criticisms of compassionate leadership

Compassionate leadership, while widely advocated in UK H&SC systems, can face several criticisms rooted in both theoretical and practical challenges. One critique centres on its individualistic focus, which risks obscuring systemic inequities and structural barriers to compassionate practice. An overemphasis on leaders' personal virtues (e.g. empathy, emotional intelligence) may inadvertently shift responsibility for organisational culture onto individuals, neglecting the role of institutional policies, funding shortfalls, and hierarchical power dynamics (Gabriel, 2015; de Zulueta, 2015). This individualisation can lead to performative compassion, where leaders adopt superficial displays of care to meet policy targets, while underlying issues, such as understaffing, excessive workloads, or toxic workplace cultures remain unaddressed (Papadopoulos et al., 2020; Tierney et al., 2019). This tokenism not only fails to alleviate staff suffering, but may exacerbate moral distress by creating a dissonance between idealised expectations and reality (Straughair, 2019; Tomkins & Simpson, 2015).

Secondly, compassionate leadership has been critiqued for its ambiguity in theoretical framework. While it draws on transformational, servant, and authentic leadership, it lacks distinct theoretical boundaries (Evans, 2022), which could lead to inconsistent implementation and evaluation. Although known as an approach, compassionate leadership has been referred to as a style, trait, cultural shift, and behaviour which means research must be clear on the context that compassionate leadership is referred to (Ramachandran et al., 2023; de Zulueta, 2021). In addition, this ambiguity complicates efforts to operationalise compassion in complex healthcare environments, where leaders balance empathy with efficiency, performance management, and resource constraints (Bailey & West, 2022b). For

example, the expectation to "listen with fascination" may clash with time-pressured clinical demands, rendering compassionate behaviours unsustainable.

Thirdly, there may be concerns about power dynamics and authority. Compassionate approaches may undermine leaders' perceived authority or decision-making, and is limited within the parameters of managerial authority (Simpson et al., 2023). Compassion may also be misinterpreted which might facilitate passive tolerance of underperformance, hindering accountability, with leaders not understanding they are required to make tough decisions (Hougaard et al., 2020; Krause et al., 2023).

Finally, the structural feasibility of compassionate leadership in under-resourced systems could be questioned. Despite efforts to improve funding and staffing, deficits remain, with time pressure and high workload environments challenging the ability to be compassionate (Harrel et al., 2021). Without continued investment in workforce well-being and systemic reform, compassionate leadership risks becoming aspirational rather than a practicable strategy.

Overall, while compassionate leadership is appealing due to its inclusive nature and learning emphasis, its implementation in healthcare can be critiqued for individualising systemic failures, theoretical vagueness, and questions remain regarding the pragmatic compatibility with ongoing resource-constrained, target-driven environments. Advocating for compassionate leadership could require a dual focus; fostering compassionate behaviours alongside addressing structural barriers to ensure sustainable, equitable change, for staff and service users (Östergård et al., 2023; West & Chowla, 2017).

1.7 Clinical Psychology and Leadership

Staff working in H&SC include, but are not limited to, nurses, occupational therapists, healthcare assistants, and social workers. Clinical Psychologists (CPs) hold a distinct leadership role within the NHS, being one of few staff groups receiving public funding for doctoral level training in healthcare (Rao & Mason, 2023). Recent figures estimate that of the 1.4 million NHS staff, 6,719 (0.48%) are CPs, compared to the 140,700 (10%) of doctors, and the 377,600 (27%) of nursing staff (The King's Fund, 2024; Rosairo & Tiplady, 2024). This could lead to a concern around the expectations of significant responsibility placed on a marginal workforce: CPs enter the workforce at Agenda for Change Band 7, a level that typically carries senior responsibilities including clinical leadership, staff supervision, and service development. In contrast, newly qualified nurses begin at Band 5, reflecting a more gradual transition into leadership roles ((NHS Employers, 2024). The limited number of CPs relative to other staff groups expected operate at an immediately senior level may create pressures around leadership capacity, sustainability, and workforce wellbeing within mental health services.

1.7.1 The clinical psychology leadership development framework (CPLDF)

The CPLDF was published in 2010 and provides a matrix of incremental and cumulative behaviours expected as CPs progress from prequalification to director level (Division of clinical psychology, DCP, 2010). The CPLDF is associated with the clinical leadership competency framework (CLCF) within the NHS, which applies to all clinicians, and is recommended for use with their relevant professional bodies policies (NHS leadership academy, 2011). Table 3 provides examples of the CPLDF for practising CPs and how the link to the CLCF.

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Table 3

Mapping of CLCF to CPLDF for Practising Clinical Psychologists

CLCF Domains	Corresponding outcomes for practising CPs
1. Demonstrating personal qualities	• Demonstrating emotional intelligence • Conflict management • 360 degree feedback
2. Working with others	• Leading multidisciplinary team formulation • Assertive and negotiation skills • Supervising and contributing to problem solving
3. Managing services	• Influence policies and procedures • Ensure quality and value for money of services • Learn from mistakes and lead on outcome measures usage
4. Improving services	• Construct service development plans • Critically appraise literature and guidelines • Inspire others to develop a culture of innovation
5. Setting direction	• Remain aware of the political and economical environment • Instigate marketing of effective practice • Use relational skills to understand the emotional impact of change and facilitate transformation through resistance

Note. Adapted from "Clinical Psychology Leadership Development Framework", by Division of Clinical Psychology, September 2010. *British Psychological Society,* 7-11.

While the CPLDF is the key leadership framework for CPs, the rapid changes of legislative, workforce, H&SC integration, and NHS strategic priorities highlighted in the prior sections has meant there is justification for the CPLDF to be refreshed to develop CPs ready for the future (Psychological Professions Network, PPN, 2020). In particular, the CPLDF does not refer to compassion or compassionate leadership, and this is concerning given the focus on culture of compassion within H&SC.

1.7.2 CP's view of their own leadership competencies

Psychological professionals repeatedly struggle to recognise their own leadership and management skills, and some may be reluctant, or lack confidence to engage with development opportunities (PPN, 2020, p. 5). One study found that final-year doctoral trainees reported minimal leadership development during training, while qualified CPs identified significant growth in leadership skills only after qualification (Channer et al., 2018). Another study in newly qualified CPs found that the motivation to lead was positively correlated with those with a transformational leadership style, those who strongly identified with the idea of leadership, those who believed their perceived capability to achieve results, though CPs also had reduced belief in their leadership capabilities (McTiffin, 2022). One study of CPs working in child and adolescent mental health services found that themes emerged regarding feeling less powerful compared to multidisciplinary colleagues; not feeling respected; challenges in building relationships; and imposter syndrome with not feeling good enough as a leader, nor being comfortable with leading (Evans, 2023). Another study found that trainee CPs requested leadership teaching to come earlier in doctoral training and to be supported by opportunities to practice leadership skills during placements, with qualified CPs calling for increased funding for psychologically informed leadership training once qualified to support good quality, continued professional development in this area (Ambrose, 2019). In a qualitative study exploring the leadership experiences of eight CPs (bands 8a–8c), participants described a navigating emotional and ethical challenges. One key theme, *losing control and perspective*, captured feelings of distress, helplessness, and frustration with themselves and others during difficult leadership moments. This was followed by a process of *regaining control and perspective*, where participants described the internal conflict of "feeling one thing, doing another", alongside experiences of growing empowerment, reconnecting with

their values, and seeking stability. A final theme, *reflections on facing dilemmas*, highlighted the ethical and emotional complexity of leadership, including tensions between doing what is right versus what is comfortable, the personal cost of inaction, and the transformation of difficult experiences into insight and growth (Messham, 2018). A study in America had found that CPs experiences of training did not fully align with the realities of many CPs typical work landscapes, and that there needed to be more focus on leadership competencies such as problem solving, strategic planning and navigating organisational power (Hunt et al., 2024).

1.7.3 Leadership development for CPs working in H&SC

The 2018 clinical psychologists as leaders (CPL) program integrated two mentoring schemes (once focused on junior psychologists, the other focused on senior psychologists) to provide a mentoring infrastructure across the career span. Despite challenges in collecting feedback, both initiatives demonstrated that mentoring positively impacted well-being, with senior psychologists reporting enhanced leadership and resilience (Rao et al., 2023a).

In 2021, the DCP initiated a project to enhance leadership capabilities among clinical CPs within H&SC sector (DCP, 2021), recognising the need to update the CPLDF in response to the evolving environment. Key leadership themes identified included fostering leadership across all career levels, addressing diversity gaps, collaborating with experts by experience, service development, adopting non-traditional roles of influence (e.g. within parliamentary groups), asserting professional autonomy, and acquiring media skills. The initiative acknowledged newly qualified CPs have limited leadership training, and emphasised compassionate leadership as a critical competency shaped by the post-COVID-19 context with compassionate leadership underpinning a proposed development matrix (DCP, 2021, p.13). This aligns CP leadership with broader healthcare leadership priorities. Further,

compassionate leadership was ranked in the top three priorities for CPs following a vote (DCP, 2021, p.14).

To address the limited availability of structured leadership development opportunities, the DCP introduced a three-day Leadership and Management Development Programme in 2024 (BPS, 2023). This programme focuses on leadership, authority, and power; fostering inclusive and compassionate actions; and enhancing skills for working with team dynamics and influence. While the programme's design reflects current leadership challenges, its outcomes have not yet been reported.

Despite the existence of at least nine established leadership programmes currently available within the NHS (NHS Leadership Academy, n.d.), they are primarily utilised by managerial staff and physical health clinicians. Emerging efforts aim to align CP leadership training with these broad established offerings, which could also help address the gap in leadership preparation for CPs and support their integration into H&SC leadership structures (BPS 2023, DCP, 2021).

1.7.4 Leadership and diversity within CP

The CP profession has been critiqued for complicity in systemic racism and alignment with structures that centre whiteness as normative (Ahsan, 2022; Wood & Patel, 2017). Historically, the CP workforce has been predominantly white and female, a trend that continues today. This demographic profile is relevant as some research suggests leadership styles may differ by gender; women generally adopt transformational styles focused on collaboration and emotional intelligence, whereas men may favour transactional approaches emphasising structure and results (Almadani & Alamri, 2024; Eagly et al., 2003; Kark et al., 2012). However, these distinctions should be interpreted cautiously. Leadership is shaped by

a complex interplay of personal, cultural, and organisational factors, and significant variation exists both within and across social identities (Apore & Asamoah, 2019; Lux et al., 2024; Minehart et al., 2020). Table 4 summarises the most recent HCPC diversity data.

Table 4

HCPC diversity data: Clinical Psychologists (HCPC 2023a).

Data point	Sub data point	Percentage (%)	Total percentage (%)
Sex	Female	79	100
	male	17	
	Prefer not to say	4	
Ethnicity	White	85	100
	Asian	5	
	Black	1	
	Mixed, other prefer not say	9	
Religion or belief	No religion	57	100
	Christian	23	
	Spiritual	3	
	Jewish	2	
	Muslim	1	
	Hindu	1	
	Sikh	1	
	Buddhist	1	
	Prefer not to say/ other	11	

This data supports recent recommendations to address diversity gaps and promote anti-racist practice in CP (DCP, 2021). Additional efforts include a national action plan to improve equity for global majority entrants in doctoral training access (Health Education England, 2021), and funding opportunities for training courses to enhance inclusion and culturally responsive training (Francis & Scott, 2023).

Representation at senior level also remains problematic, with only 11% of NHS trust board positions held by individuals from global majority backgrounds, despite comprising

approximately 26% of the workforce (NHS England, 2024a). Greater representation in CP leadership could mean mental health services better reflect the diverse populations served, and improve patient outcomes (Gomez & Burnet, 2019; NHS England, 2020a). Increasing diversity in CP leadership may enhance the cultural relevance of mental health services and improve outcomes for diverse populations (Gomez & Burnet, 2019; NHS England, 2020a). Addressing these gaps can also reduce barriers to care, such as stigma, lack of culturally competent services, and systemic mistrust (Alam et al., 2024; Jieman et al., 2024).

1.8 Parity of Esteem and the Mental Health Implementation Plan (MHIP)

The parity of esteem, enshrined in the Health and Social Care Act (2012) mandates the equal value of mental and physical health. Thirteen years on, this remains a significant challenge within H&SC. Many mental health services still lack defined standards, and gaps in data completeness and quality make it difficult to plan and provide care (Gilburt & Mallorie, 2024a; National Audit Office, 2023). In 2019, the LTP committed to £2.3 billion annual in increase mental health services investment until 2024 (NHS England, 2019a). The accompanying MHIP laid out key strategies on how this would be delivered, predominantly through expanding the psychological workforce. The MHIP aimed to reduce inequalities in access, waiting times, overdiagnosis, and treatment, with a particular focus on improving services for marginalised groups (NHS England, 2020b) and fostering collaboration with the voluntary and community sectors where CPs increasingly work (Rao & Mason, 2023). The impact of COVID-19 further exacerbated these disparities, undermining progress towards true parity (National Audit Office, 2023; Public Accounts Committee, 2023). Thus, significant gaps remain, for example, individuals with severe mental health difficulties are five times more likely to present in urgent care than those without (Lewis et al., 2023), and regional variations

in spending on children's mental health, ranging from £34 to £141 per child in 2021/22 (Children's Commissioner, 2015, as cited in Gilburt & Mallorie, 2024b).

CPs represent around 24%[6] of the psychological workforce (NHS Benchmarking Network, 2023), and play a vital leadership role in the delivery of the MHIP through co-produced, locally responsive services that reflect the needs of communities. However, despite increased investment, challenges remain, particularly concerning workforce experience levels in the rapidly expanding sector (NHS England, 2019b; Gilburt & Mallorie, 2024c).

The ongoing challenges require compassionate leadership in addressing systemic inequities in mental health care. CPs as leaders, are uniquely positioned to navigate these complexities by fostering a compassionate approach in their services. The pressures of workforce expansion and leading in rapidly changing service environments require not only technical expertise but also emotional resilience, empathy and a learning culture. Compassionate leadership in this context means recognising the emotional and psychological needs of staff, ensuring they feel supported in their roles, and promoting a culture that prioritises well-being alongside performance. Achieving parity of esteem will require sustained efforts from CP leaders to balance the demands of service delivery with the core values of compassion and care.

1.9 Summary rationale and research-practice gap

The pandemic called for 'a new approach to leadership based on the core value of compassion' (Bailey & West, 2022b). A potential way of applying Gilbert's (2009) three-systems model in line with evidence could indicate many healthcare professionals

[6] NHS benchmarking acknowledges that there is missing data (p.10) from their workforce census, so this statistic is likely to be underreporting, and also does not include H&SC staff.

experienced prolonged overactive threat and drive systems, triggered by ambitious metrics and service developments, while feeling threatened by inequality, organisational mistrust, under-resourcing, and distressing situations (Koontalay et al., 2021; NHS Providers, 2024; Robertson et al., 2021; Williams, 2024). This imbalance, with little activation of the soothing system, contributed to widespread psychological distress, including burnout, moral injury, and compassion fatigue, prompting some to leave the workforce (Gemine et al., 2021; Giebel et al., 2021; Hollingsworth, 2024; Marshman, 2022; al., 2021; Public Accounts Committee, 2023; San Juan et al., 2020).

Consequently, leadership has become a critical focus area post-pandemic (NHS Confederation, 2022a), with compassionate leadership increasingly recognised as essential to supporting workforce wellbeing and care quality (Bailey & West, 2020). However, leadership research in mental health and learning disability services, where CPs predominantly work, remains limited, and significantly trails behind that of medical and nursing professions (Gravestock, 2023; Malenfant, 2022; Östergård et al., 2023; Ramachandran et al., 2023; Rooney, 2020). Much existing CP leadership literature is policy-based rather than empirical. While psychological profession frameworks now acknowledge compassionate leadership, further engagement is needed, particularly as CPs often report feeling underprepared for leadership (Channer et al., 2018; DCP, 2021; PPN, 2020; Rao & Mason, 2023). Further, there have only been a handful of unpublished doctoral dissertations regarding CP leadership, which is acknowledged in section 2.1, where it is unknown if these have influenced CP leadership practice. Leadership research in social care is emerging, recognising the sector's vital contribution to integrated service delivery (MacLochlainn et al., 2023; McFadden et al., 2023).

These lags and gaps are concerning in light of the parity of esteem agenda, which commits to valuing mental and physical health equally. As the mental health workforce expands and CPs assume broader responsibilities in complex post-pandemic systems, their inclusion in the advancing leadership research and guidance are essential (Rao & Mason, 2023). Doing so will help CPs co-produce leadership models alongside their healthcare peers and contribute to building compassionate H&SC systems.

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2.0 Systematic Literature Review

2.1 Chapter Overview

This chapter details the process of a systematic literature review (SLR) which includes identifying, organising, and critically evaluating relevant literature to understand more about the leadership experiences of mental health professionals and the settings in which they work. An SLR rigorously adheres to a methodical and transparent approach to identifying, appraising and synthesising large bodies of existing research on a specific topic (Kuckertz & Block, 2021; Siddaway et al., 2019). By following a predefined methodology, SLRs address potential biases and limitations often associated with traditional literature reviews. SLRs offer several advantages in that they can help identify knowledge gaps, inform evidence-based practice, and guide future research directions (Page et al., 2020).

2.1.1 Rationale for the current SLR

The question *"What are healthcare leaders' experiences of compassionate leadership?"* has been recently explored (Östergård et al., 2023). To identify whether similar leadership research existed for clinical psychologists, initial scoping searches in PsycNet and CINAHL using terms like "psychologist" and "leader" showed most results were theoretical, position statements, service-evaluations, or outside mental health contexts (e.g. schools or corporate settings).

Primary research examining clinical psychologists' leadership experiences remains sparse. Although grey literature is increasingly accepted in SLRs to reduce publication bias and ensure timely dissemination (Harari et al., 2020; Hoffecker, 2020), the lack of a systematic search process via Google Scholar and the influence of Google's personalised algorithm constrained the systematic inclusion of several unpublished doctoral theses (e.g. Ambrose,

2019; Cartmell, 2020; Corrigall, 2015; Evans, 2023; Hunter, 2015; McTiffin, 2022; Messham, 2018; Williams, 2023). Doctoral theses are acknowledged to meet scientific, ethical, and professional standards (Evans et al., 2018; Goodman et al., 2020), and while not an exhaustive list, this sparse internal body of research could be considered by psychology system leaders to help bridge the gap between research and practice within clinical psychology leadership.

A recent scoping review on burnout and leadership in mental health clinicians also highlighted the need for more research (Gravestock, 2023). Given chapter one's revelation of the field's heavy emphasis on physical health settings and broader professions, the SLR scope was expanded to explore the question:

What is currently known about leadership experiences of mental health professionals in the settings in which they work?

2.2 SLR Method

2.2.1 Databases, search strategies, and search outcomes

Recent reviews in the field of healthcare leadership had used databases such as CINAHL, Scopus, Pubmed, and Psyc info, and as such these were seen as the most relevant databases to search (Gravestock, 2023; Östergård et al., 2023). Table 5 provides the search strategy conducted on the 17th January 2025 with the number of results shown too, with results shown between the years 2010 to 2024.

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Table 5

Databases, search strategies and search outcomes

Database	Search Strategy	*n*
CINAHL	Combined search "#1 AND #2" #1 Title OR Abstract: leader* OR leading OR "leadership style*" #2 Title OR Abstract: psychologist* OR "psychological therapist*" or "psychological practitioner" or "mental health leader*" or "CBT Therapist*" or "mental health nurs*" OR "mental health worker*" or "mental health clinician*" or "mental health staff" OR "mental health service*" OR "mental health setting*" OR "child and adolescent mental" or CAMHS or "Community mental" or CMHT "eating di*" OR IAPT or "psychiatrist*" or "psychiatric nurs*" OR "psychiatric ward" or "psychiatric unit" or "psychiatric department" or "psychiatric hospital" or "psychiatric staff" or "learning disabilit*" or "intellectual disabilit*" or ("mental health" N3 forensic) OR ("mental health" N3 inpatient) OR ("mental health" N3 "older adult") OR ("mental health" N3 "early intervention") OR ("mental health" N2 interdisciplinary) OR ("mental health" N2 multidisciplinary) OR (psychiatric N3 forensic) OR (psychiatric N3 inpatient) OR (psychiatric N3 "older adult") OR (psychiatric N3 "early intervention") OR (psychiatric N2 interdisciplinary) OR (psychiatric N2 multidisciplinary)	2375
PsycNet	Combined search "#1 AND #2 #1 Title OR Abstract OR Keyword: leader* OR "leadership style*" OR leading # 2 Title OR Abstract OR : "psycholog*" OR "mental health nurs*" OR "mental health worker*" or "mental health clinician*" or "mental health staff" OR "mental health service*" or "mental health setting*" OR "child and adolescent" OR CAMHS OR CMHT OR "learning disabilit*" OR "intellectual disabilit*" or "Older adult*" or "inpatient" or "eating di*" or "IAPT" OR forensic or "psychiatric" or "community mental" or NHS or "national health service" OR "multidisciplinary mental" or "interdisciplinary mental"	1427
Pubmed	Combined search "#1 AND #2 AND #3" #1 Title or Abstract: leader* OR "leadership style*" OR leading #2 Text word: "mental health setting*" OR "mental health service*" OR "mental health staff" OR "mental health clinician*"	1980

	OR "mental health worker*" OR "multidisciplinary mental" OR "interdisciplinary mental" #3 Default: "psycholog*" OR "mental health nurse*" OR "mental health worker*" OR "mental health clinician*" OR "mental health staff" OR "mental health service*" OR "mental health setting*" OR "child and adolescent" OR CAMHS OR CMHT OR "learning disabilit*" OR "intellectual disabilit*" OR "Older adult*" OR "inpatient" OR "eating di*" OR "IAPT" OR forensic OR "psychiatric" OR "community mental" OR NHS OR "national health service"	
Scopus	Combined search "#1 AND '2" #1 Title OR Abstract OR Keyword: leader* OR "leadership style*" OR leading #2 Title or Abstract OR Keyword: psychologist* OR "psychological therapist*" or "psychological practitioner" or "mental health leader*" or "CBT Therapist*" or "mental health nurs*" OR "mental health worker*" or "mental health clinician*" or "mental health staff" OR "mental health service*" OR "mental health setting*" OR "child and adolescent mental" or CAMHS or "Community mental" or CMHT "eating di*" OR IAPT or "psychiatrist*" or "psychiatric nurs*" OR "psychiatric ward" or "psychiatric unit" or "psychiatric department" or "psychiatric hospital" or "psychiatric staff" or "learning disabilit*" or "intellectual disabilit*" or ("mental health" W/3 forensic) OR ("mental health" W/3 inpatient) OR ("mental health" W/3 "older adult") OR ("mental health" W/3 "early intervention") OR ("mental health" W/2 interdisciplinary) OR ("mental health" W/2 multidisciplinary) OR (psychiatric W/3 forensic) OR (psychiatric W/3 inpatient) OR (psychiatric W/3 "older adult") OR (psychiatric W/3 "early intervention") OR (psychiatric W/2 interdisciplinary) OR (psychiatric W/2 multidisciplinary)	790

The search revealed 6572 results, which were then imported into a bibliographic management system Covidence 2.0.

2.2.2 Inclusion and exclusion criteria

To synthesise qualitative research, the SPIDER tool (Cooke et al., 2012) was used to summarise the inclusion and exclusion criteria, as shown in Table 6.

Table 6

SPIDER Criteria (Cooke et al., 2012)

SPIDER	Inclusion	Exclusion
(S) Sample by profession	Mental health professionals, learning disability professionals, clinical psychologists, therapists, psychiatric/ mental health nurses, managers, executives	General nurses, medical doctors, pharmacists, non-mental health professionals
(S) Sample by setting	Mental health settings or services, Community mental health teams, child and adolescent mental health services, older adult, inpatients, learning/ intellectual disabilities services, forensic, IAPT, National health service, Developed countries	Non- mental health settings, e.g. Military, school, corporate businesses.
(PI) Phenomenon of Interest	Being a leader, enacting leadership	Supervision, reflective practice, or consultation as the primary focus
(D) Design	Research methodology, participants, ethical approval	No participants, reflective pieces, descriptive or theoretical articles, literature reviews,
(E) Evaluation	Outcomes, experiences, traits, leadership as the focus	Perceptions of becoming a leader, no documentation on experiences, leadership programs, policy/ strategic interventions, recommendations for leadership where leadership was not the focus of the paper,
(R) Research method	Qualitative, mixed methods	Quantitative, reflective pieces

To minimise gaps in research, it is important to recognise the diverse contexts in which mental health professionals operate. Professionals such as clinical psychologists and mental health nurses, work across multiple domains such as learning disability services, forensic units, and inpatient care, where mental health needs often overlap. While learning disabilities and mental health are distinct fields, the involvement of mental health professionals across these

settings underscores the breadth of their roles. Additionally, although supervision, reflective practice, and consultation are vital components of leadership, this review focuses on clinical and system leadership rather than developmental sub-responsibilities that, while important, may not fully capture leadership's multidimensional nature in mental health care.

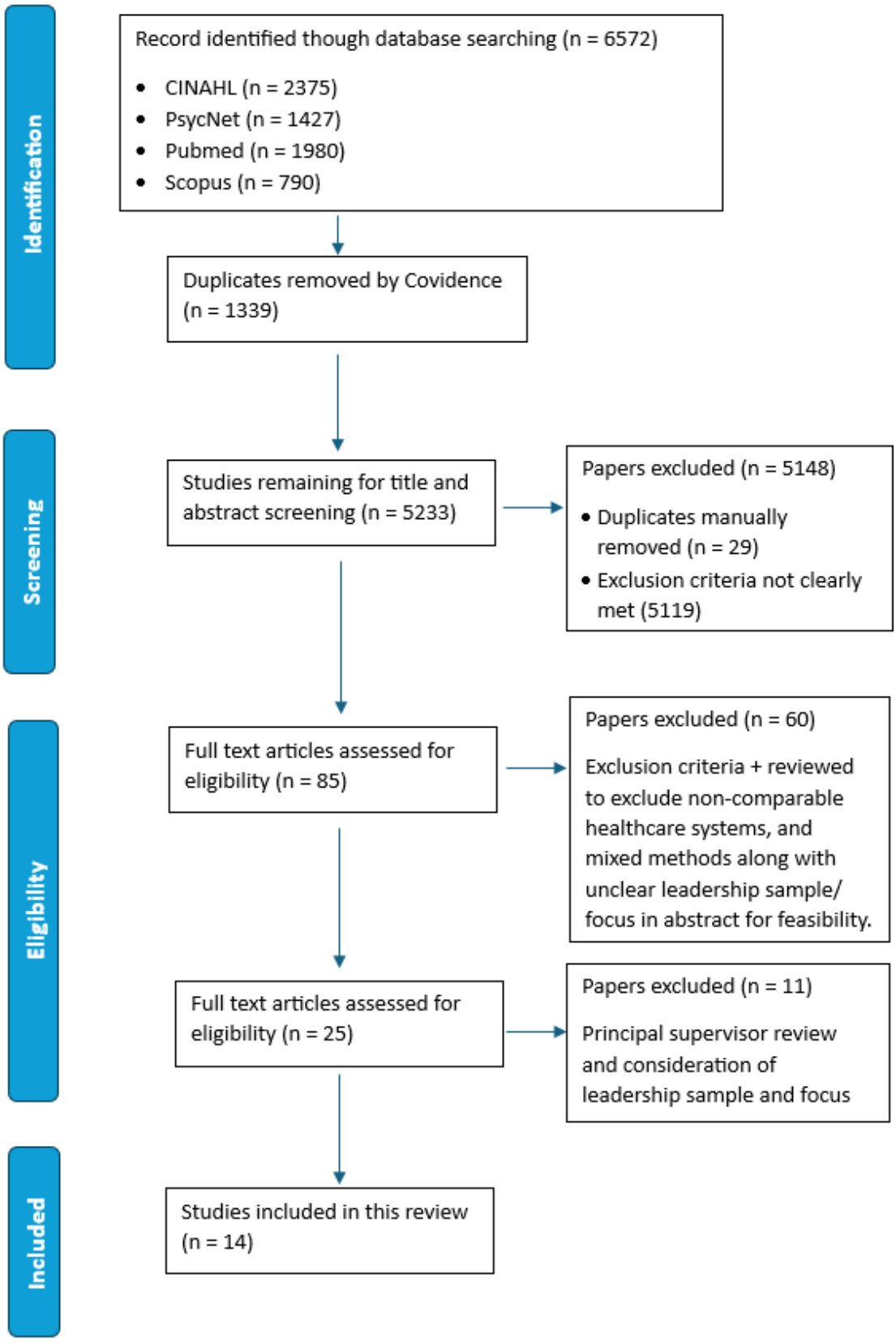
This review focused on leadership experiences, prioritising qualitative, and mixed-method studies with qualitative data, as these best capture in-depth perspectives. Only English-language studies were included. Due to limited UK-based research, studies from countries with Western healthcare systems were considered, as they could offer greater similarities and relevant insights into mental health leadership.

2.2.3 Search results

Once search files from the databases were imported into Covidence, 5233 studies remained after 1339 duplicates were automatically identified. Following title and abstract screening against inclusion criteria, 85 studies remained for full text screening with further duplicates manually removed. At this point a decision was made to focus on research undertaken in countries with broadly comparable healthcare systems to the UK. This resulted in the inclusion of European and Australian papers. This reduced the number of papers for this review down to 25. The principal supervisor was then consulted to jointly agree papers that made the final selection. PRISMA (Preferred Reporting Items for Systematic Reviews) guidelines in Figure 3 shows the process of screening and selecting studies for inclusion (Page et al., 2021). This offers a transparency when reporting systematic reviews.

Figure 3

PRISMA Flow Diagram of Systematic Literature Search (Page et al., 2021)



2.3 Included studies

All included studies employed qualitative designs. Geographically, six were conducted in England, three in Norway, three in Australia, one in Sweden, and one in Ireland. The full-text screening process posed challenges, as many studies included leaders within their sample but did not explicitly focus on leadership experiences. Additionally, some studies combined leaders and non-leaders without distinguishing their perspectives. To ensure relevance, studies were included where findings meaningfully reflected the views or actions of those in leadership roles either through direct accounts or through themes related to leadership, and where the sample included individuals in leadership positions. This judgement-based approach ensured the synthesis captured a rich and representative understanding of leadership across diverse mental health settings. A summary of the 14 studies along with strengths and limitations are shown in table 7.

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Table 7

Studies Included in the Systematic Literature Review

Title, Author, Year, and Country	Aims	Participants	Data Collection and Analysis	Summary of Findings	Strengths and Limitations
Making It Work: The Experiences of Delivering a Community Mental Health Service during the COVID-19 Pandemic. Burton, Wall & Perkins (2022). England.	To understand community-based frontline staffs experiences of leadership during the pandemic and their ability to deliver community care in a crisis.	21 CMHT staff (Nurses, physiotherapists, social workers, support workers, managers)	• Purposive (advertised) sampling. • Semi structured interviews. • Constant comparative thematic analysis. • CoREQ Checklist	Frontline staff felt excluded from decision making, authoritarian leadership necessary in crisis but gave limited transparency. Discrepancies between leadership structure and frontline reality. Hospital staff were prioritised over community staff. Frequently changing messages and poor communication lead to confusion. Conflicting demands between protecting staff wellbeing and providing care in high pressure situations.	Strengths: large sample for thematic analysis. COREQ checklist used. Ethical procedures were followed. Limitations: Represents one CMHT in the West of England. Leadership in the first wave of the pandemic, quite specific. Could have included more leaders e.g. psychiatrists.

Title, Author, Year, and Country	Aims	Participants	Data Collection and Analysis	Summary of Findings	Strengths and Limitations
Practice Leadership at the Front Line in Supporting People with Intellectual Disabilities and Challenging Behaviour: A Qualitative Study of Registered Managers of Community-based, Staffed Group homes. Deveau & McGill (2015). England.	To explore how managers in adult intellectual disability services influence staff behaviour (i.e. act as practice leaders) in line with evidence-based policy and practice	19 registered managers in adult residential services	• Purposive Sampling (Convenience from a prior study) • Semi structured interviews. • Interpretative phenomenological analysis.	Five groups of themes emerged: monitoring staff performance, supporting new ways of working, shaping staff performance, influence of external and employing agencies, and importance of participants' personal values and experiences.	Strengths: Large sample for IPA. Adds to limited research in front line management in intellectual disability. Participants likely to be highly committed, providing rich data. Limitations: Interviews were short for an IPA. IPA is subjective. Other aspects of manager competence were not included.
Contextual and individual barriers to providing practice leadership by frontline managers in community services for adults with intellectual disabilities: A qualitative study. Deveau & Rickard (2024). England.	1. What is frontline managers' experience of providing practice leadership? 2. What are the barriers to practice leadership by frontline managers?	14 frontline managers of services for adults with learning disabilities living in staffed housing in the community.	• Purposive sampling • Semi structured interviews. • Thematic analysis.	Three themes emerged reflecting participants' experiences of barriers to work as practice leaders, focusing on stable staff teams, 'admin' and paperwork, and developing staff, each with sub-themes such as training, confidence and competence, and resistance to change.	Strengths: Managers agreed the results are a fair summary of the 'state of play'. Sample all had frontline managerial responsibility. Limitations: Themes were developed by a single researcher. Results dependent on managers disclosures and willingness to share.

Title, Author, Year, and Country	Aims	Participants	Data Collection and Analysis	Summary of Findings	Strengths and Limitations
Multi-professional approved clinicians' contribution to clinical leadership. Ebrahim (2018). England.	To understand how multi-agency approved clinicians can enable clinical leadership and care provision in mental health settings and to explore the barriers and enablers to the implementation of the roles in practice.	23 clinicians. 51% were in NHS 8C equivalent positions. Clinical psychologists and mental health nurses.	• Purposive sampling. • semi structed interviews. • Thematic analysis.	Themes focused on enabling person-centred care, clinical leadership and culture change. The AC role supports clinical leadership, promoting patient choice by enabling access to clinicians with the appropriate skills to meet needs. Clinical leaders promote links between organisational priorities, teams and patient care, fostering distributed leadership in practice.	Strength: Acknowledges the role of power and psychiatry influence. Highlights distributed leadership as a style of the role, along with culture change. Limitations: Reflects the views of a limited number of practitioners within one organisation which limits generalisability.
A qualitative exploration of the role of leadership in service transformation in child and adolescent mental health services. Edbrooke-Childs (2019). England.	To focus on the role of leaders and frontline practitioners as collective approaches to leadership. To understand the role of local leadership in transforming CAMHS from both leaders' and practitioners' perspectives.	3 commissioners, 17 managers, and 29 practitioners. All staff involved in a service transformation in a child and young person psychology service.	• Secondary analysis of semi structured interviews. • Framework analysis and thematic analysis.	Leaders: (a) support transformation by showing passion and commitment for change (b) support practitioners in developing microsystem improvements, and (c) bridge organisational goals with available resources. Leaders should be transparent about reasoning and processes behind transformation and enable staff to tailor implementation to need.	Strengths: Framework analysis is suitable for a large sample. Leadership was explicitly the focus. Limitations: Unclear what leadership responsibility the practitioners had. Secondary analysis and so the interviews may not have asked relevant questions to this study

Title, Author, Year, and Country	Aims	Participants	Data Collection and Analysis	Summary of Findings	Strengths and Limitations
Intentional Modelling: A Process for Clinical Leadership Development in Mental Health Nursing. Ennis, Happell, & Reid-Searl (2016). Australia.	To examine the process of developing clinical leadership skills from the perspective of peer identified clinical leaders in mental health nursing.	Nurses working in public mental health settings, who were identified as leaders from the peers.	• Purposive sampling (Peer nomination) • Semi structured interviews. • Grounded theory.	Intentional modeling is a process that enabled mental health nurses to purposefully identify role models to help them develop characteristics of effective clinical leaders, as well as allow them to model these characteristics to others. Reflection on practice is an important contributor to intentional modelling.	Strengths: Nurse leaders were chosen by peers which could indicate their contributions are highly valid. Grounded theory was appropriate given paucity of knowledge in the area. Limitations: unknown sample size so unable to deduce how much data was used to generate the theory.
Impact of organisational change for leaders in mental health. Frawley, Meehan, & De Brún (2018). Ireland.	To examine the impact of organisational and structural change on the evolution of quality and safety in mental health services.	25 executive management team members from 5 mental health services.	• Purposeful sampling • Semi structured interviews with a precursor questionnaire. • Thematic content analysis.	Three themes emerged: (a) organisational characteristics, leadership and accountability; (b) sustaining collaboration and engagement with stakeholders; and (c) challenges and facilitators of quality and safety. There is a disruptive impact of on-going organisational change and restructuring on leaders' ability to focus on and develop the quality and safety agenda.	Strengths: Makes real world suggestions such as clinical staff training, consideration of appropriate perfomance measures, improved IT systems, and clearer accountability for good governance. Limitations: The elicitation of single respondents' views on complex issues. Cautious to generalise findings.

Title, Author, Year, and Country	Aims	Participants	Data Collection and Analysis	Summary of Findings	Strengths and Limitations
Collaborative practices between correctional and mental health services in Norway: Expanding the roles and responsibility competence domain. Hean, Willumsen & Ødegård (2017). Norway	Exploring the characteristics of collaborative practices between the Mental health services and prison services.	12 leaders from mental health and correctional services. 3 lawyers, 4 social workers, 2 nurses, medical doctor, psychiatrist, family therapist.	• Purposive sampling. • Semi structured interviews. • Inductive thematic analysis.	4 themes emerged. A) Expected collaborative practice and distributed responsibility across all staff to make decisions. B) Navigating complex external structures of varying expertise is challenging. C) Resource limitations, logistical issues, hinder effective collaboration and responsibility-taking. D) Positive attitudes to clients help along with being proactive in resolving issues.	Strengths: Participants very highly experienced. Study focused on responsibility distribution as a key part of collaborative practice. Limitations: English was the second language for participants. Not all areas of the system studied were represented. Collaboration is intangible and focus should be on specific activities.
Exploring the role of the nurse unit manager(NUM) in forensic mental health inpatient units: A qualitative study. Maguire, Mawren, Ryan, Ennis, & Olasoji (2023). Australia.	To explore the experience of nurse unit managers and obtain a comprehensive understanding of their role within the forensic mental health service.	31 in total. 5 NUMs, 10 who are managed by NUMs, and 16 who work with, or manage the NUMs.	• Purposeful sampling. Focus groups. • Thematic analysis. • CoREQ Checklist	Four themes emerged (i) lack of role clarity and boundaries (ii) the importance of clinical leadership and forensic mental health knowledge (iii) Step up in responsibility and step down in pay and (iv) seeing the difference you make in service users and developing staff.	Strengths: real world application; there is a need to support nurse managers in forensic mental health settings with capabilities to thrive as managers. Large sample, although 10 were not leaders, 22 were leaders. Limitations: Only conducted in one service which may limit generalisation to other settings. No participant checking of transcripts occurred.

Title, Author, Year, and Country	Aims	Participants	Data Collection and Analysis	Summary of Findings	Strengths and Limitations
Authenticity, Creativity and a Love of the Job: Experiences of Grassroots Leaders of Mental Health Nursing in Queensland. McAllister, Happell & Bradshaw (2013). Australia.	To articulate the contribution of MHNs to contemporary mental health services in recent times; and to appreciate the importance of mental health nursing to the broader nursing profession.	19 mental health nurses recognised by their peers as nurse mental health leaders.	• Purposive sampling. • Semi structured interviews. • Exploratory approach. • Critical interpretation thematic analysis.	Three themes were identified. a) Deep satisfaction from positive patient impact defines the intrinsic rewards. b) Authentic human connection is paramount in therapeutic practice. c) Creative and adaptable methods are crucial for achieving therapeutic success. Attributes such as person-centeredness, willingness to be present, and creative engagement and support approaches were evident from these mental health nursing leaders.	Strengths: Participants' reflections offer a deeper layer of meaning about the nature of connecting with people than a list of skills or tasks. Limitations: No limitations section. Unclear what the exact leadership roles of participants despite a description saying they were longstanding leaders.
Frontline leadership for implementing clinical guidelines in Norwegian mental health services: a qualitative study. Nordin, Rørtveit, Mathisen et al. (2022). Norway.	To explore and interpret how frontline leaders define, experience and rationalise their approaches to the successful implementation of clinical guidelines in mental health care.	10 nurses, 2 psychologists, and 2 social workers all with leadership experience in mental health services	• Purposive sampling. • Semi structured interviews. • Interpretative phenomenological analysis. • CoREQ Checklist	Three approaches were found. (a) Curious and welcoming" is an openness to organisational and professional changes while being reflexive, non confrontational, and flexible, or an emotionally intelligent leader. (b) "Integrity and setting standards" is a focus on competence, fairness, honesty, own contribution and interdisciplinary teamwork. (c) "Caring and collegial" engagement on behalf of co-workers with a responsibility to maintain order and predictability.	Strengths: The sample was fairly homogenous which is desired for an IPA. Two members of the research team controlled for interview bias and no signs of bias was observed. Limitations: The findings are accounts of phenomena. 10 participants were female nurse leaders, so cautious generalisation is required as other leadership identities may provide different views.

Title, Author, Year, and Country	Aims	Participants	Data Collection and Analysis	Summary of Findings	Strengths and Limitations
Implementing Clinical Guidelines for the Treatment of Psychosis: The Frontline Leaders' Point of View. A Qualitative Study. Nordin, Mathisen, Rørtveit et al. (2024). Norway.	To explore how frontline leaders comprehend their own implementation intentions and actions, and how these intentions and actions may influence implementation of clinical treatment guidelines in mental healthcare.	9 frontline psychiatric leaders. 2 had more than ten years of leadership experience, 4 had nine years of leadership experience and 3 had seven years of leadership experience.	• Purposive sampling. • Semi structured interviews. • Systematic Text Condensation, informed by Normalization Process Theory. • CoREQ Checklist	Frontline leaders with high implementation success describe relation-orientation, trust, and providing space for staff members to take initiative. High-performing leaders actively involved their teams, listened to concerns, and encouraged innovation. They also had better relationships with their superiors, negotiating solutions rather than following orders. Less successful units describe more control and guidance, and place more emphasis on information and knowledge.	Strengths: strong theoretical foundation by using complexity leadership theory and normalisation process theory to analyse success. Systematic text condensation for qualitative analysis ensured rigorous data analysis. Limitations: Limited professional diversity, and conducted within a highly specific psychosis service.
Responsibility as professional leadership and decision making: Interviews with non-medical Responsible Clinicians. Oates, Burrell, Ebrahim et al. (2020). England and Wales.	To explore the experiences of non-medical Responsible Clinicians, to inform our understanding of interprofessional dynamics and professional identity in contemporary mental healthcare.	7 consultant psychologists and 5 consultant nurses, all were responsible clinicians.	• Purposive sampling. • Semi structured interviews. • Inductive thematic analysis. • CoREQ checklist	Two themes emerged. (a) Responsibility as Leadership : RCs fostered inclusive decision-making, flatten hierarchies, and increase patient involvement in care planning. They supported a team culture where all voices matter, rather than top-down authority. (b) Responsibility as Decision-Making: RCs made high-stakes decisions balancing patient care, patient rights, public safety and clinical risk. RCs struggled initially but grew more confident over time. RCs actively participated in difficult moments (e.g. forced	Strengths: Real world application of use of power to influence, as well as holding accountability. The findings can inform developments of the non-medical RC role. Limitations: Did not interview psychiatrist RCs and there was no prior research on psychiatrist views of the RC role with which to compare findings. The study reflects experiences of English and Welsh mental health laws-

Title, Author, Year, and Country	Aims	Participants	Data Collection and Analysis	Summary of Findings	Strengths and Limitations
				medication), rather than delegating.	structures may differ in other regions.
Nurses' leadership in psychiatric care- A qualitative interview study of nurses' experience of leadership in an adult psychiatric inpatient care setting. Sundberg, Vistrand, Sjöström & Örmon. (2021). Sweden.	To highlight nurses' experiences of leading the psychiatric nursing care in an adult psychiatric context.	11 registered nurses with leadership experience in psychiatric settings.	• Purposive (convenience) sampling. • Semi structured Interviews. • Inductive content analysis.	The main theme was leading with uncertainty and meaningfulness. Four sub themes were responsibility, control, powerlessness, and uncertainty. Leaders described needing to be supportive and confident. Leaders also had to know their staff and provide supportive structures. Leaders felt powerless when staff were unmotivated and at times felt inadequate, in found it difficult when undermined as a leader. Uncertainty arises when it is unclear who leads, and when one is a novice in leadership.	Strengths: The study highlights that the mandate to lead is different in different settings, which illuminates why there may be uncertainty in the leadership role. Rigour was followed in the analytic process. Limitations: The nurses specifically worked with psychosis and addiction and nurses working with other populations may report different experiences.

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2.4 Quality Assessment

Quality appraisal is a key stage in systematic reviews, ensuring methodological rigour and objectivity, helping to ensure that evidence is reliable and relevant to inform clinical practice (Majid & Vanstone, 2018; Munn et al., 2018). As all the studies included in this review were qualitative, a single appraisal tool, the Critical Appraisal Skills Programme (CASP) Qualitative Studies Checklist, was used (CASP, 2024). The CASP is the most used tool for quality appraisal in health-related qualitative evidence syntheses, with support from the World Health Organisation, and the Cochrane Qualitative and Implementation Methods Group (Long et al., 2020; Noyes et al., 2018). Designed to assess the rigour, credibility, and relevance of qualitative research, the CASP includes 10 items covering aspects such as research aims, methodology, design, data collection, ethics, and clarity of findings. Table 8 summarises how each paper meets the CASP criteria.

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Table 8

Critical Appraisal of Included Studies

Study, Author, and Location	Was there a clear statement of the aims of the research?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?
Making It Work: The Experiences of Delivering a Community Mental Health Service during the COVID-19 Pandemic. Burton, Wall & Perkins (2022). England.	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Provides insight to the experiences of leadership approaches in mental healthcare. It questions if it would be beneficial for frontline workers to be more involved in how policy decisions translate to practice, particularly in a crisis.
Practice Leadership at the Front Line in Supporting People with Intellectual Disabilities and Challenging Behaviour: A Qualitative Study of Registered Managers of Community-based, Staffed Group homes. Deveau & Mcgill (2015). England.	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes, but interviews were shorter than usual for IPA, but larger than usual sample size	Yes	The themes identified contribute to a conceptual framework for thinking about front-line management/ practice leadership.

Study, Author, and Location	Was there a clear statement of the aims of the research?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?
Contextual and individual barriers to providing practice leadership by frontline managers in community services for adults with intellectual disabilities: A qualitative study. Deveau & Rickard (2024). England.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Reinforces the view that implementing policy requires experienced frontline managers to train staff and provide support through challenging times. Administrative duties due to regulatory and financial pressures are barriers. Individual factors such as personal ability, development and confidence of frontline managers, requires further research.
Multi-professional approved clinicians' contribution to clinical leadership. Ebrahim (2018). England.	Yes	Yes	Yes	Yes	No	Yes*	Yes	Yes	This study provides initial qualitative data on potential benefits and challenges of implementing the role of an AC. An organisational strategy is needed to promote role deployment. Clarification is needed on issues such as job descriptions, job-plans, protected time, remuneration, and additional resources.

Study, Author, and Location	Was there a clear statement of the aims of the research?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?
A qualitative exploration of the role of leadership in service transformation in child and adolescent mental health services. Edbrooke-Childs (2019). England.	Yes	Yes	Yes	Partially-secondary analysis	Can't tell	Yes	Yes	Yes	Leaders should be transparent about reasoning and processes behind service change and provide support to enable staff to tailor implementation to need.
Intentional Modelling: A Process for Clinical Leadership Development in Mental Health Nursing. Ennis, Happell, & Reid-Searl (2016). Australia.	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Intentional modeling may offer an alternative approach traditional leadership or management roles and provide emerging clinical leaders a deeper understanding of the attributes they should develop to fulfill their leadership potential within a clinical setting.
Impact of organisational change for leaders in mental health. Frawley, Meehan, & De Brún (2018). Ireland.	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	The study explored an identified gap in the literature on the impact of on-going organisational re-structuring and transformation on the evolution of quality and safety in mental health services

Study, Author, and Location	Was there a clear statement of the aims of the research?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?
Collaborative practices between correctional and mental health services in Norway: Expanding the roles and responsibility competence domain. Hean, Willumsen & Ødegård (2017). Norway	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Collaborative practice is primarily exercised through the distribution of responsibility for offender care across systems, shaped by complex structures and individual factors. However, this is compromised by resource constraints, logistical barriers, and negative attitudes towards the offender population.
Exploring the role of the nurse unit manager(NUM) in forensic mental health inpatient units: A qualitative study. Maguire, Mawren, Ryan, Ennis, & Olasoji (2023). Australia.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	The findings were that role of the NUM was not clearly defined within the setting and NUMs often find themselves conflicted in direction. This can lead to a situation where they are working sub optimally, or to their full capacity.

Study, Author, and Location	Was there a clear statement of the aims of the research?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?
Authenticity, Creativity and a Love of the Job: Experiences of Grassroots Leaders of Mental Health Nursing in Queensland. McAllister, Happell & Bradshaw (2013). Australia.	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	The research claim is that mental health nursing practice is not reducible to component parts; it is true holism and involve activities that allow staff to feel, and be fully human, and to always have worth. It is humanistic, person-centred, and creative in practice.
Frontline leadership for implementing clinical guidelines in Norwegian mental health services: a qualitative study. Nordin, Rørtveit, Mathisen et al. (2022). Norway.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	The study adds knowledge about a variety of leadership approaches to achieve guideline implementation in mental health care. The results add knowledge about leadership attitudes, thinking and action. This could be useful for employers when recruiting clinical leaders and undertaking leadership development, implementation processes, and quality and safety improvement.

Study, Author, and Location	Was there a clear statement of the aims of the research?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?
Implementing Clinical Guidelines for the Treatment of Psychosis: The Frontline Leaders' Point of View. A Qualitative Study. Nordin, Mathisen, Rørtveit et al. (2024). Norway.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Frontline leaders with high degree of implementation success were aligned to all four constructs of the Normalization Process Theory (Coherence, Cognitive participation, Collective action and Reflexive monitoring), while frontline leaders with less success had more fragmented descriptions. Successful leaders appear more relation-oriented compared to those in less successful teams.
Responsibility as professional leadership and decision making: Interviews with non-medical Responsible Clinicians. Oates, Burrell, Ebrahim et al. (2020). England and Wales.	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	The research provides insights into the experiences of non-medical RCs, highlighting leadership challenges, role complexity, and decision-making under the Mental Health Act. Its value lies in informing policy and professional development for non-medical RCs.

Study, Author, and Location	Was there a clear statement of the aims of the research?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?
Nurses' leadership in psychiatric care—A qualitative interview study of nurses' experience of leadership in an adult psychiatric inpatient care setting. Sundberg, Vistrand, Sjöström & Örmon. (2021). Sweden.	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Leadership ambivalence is prominent among psychiatric care nurses. Feelings of responsibility and meaningfulness are mixed with feeling powerless and uncertain. A mandate to lead and guidance in communication and team building could reduce feelings of uncertainty. Heightened awareness within the system about nurse's leadership challenges for the most severe psychiatric illnesses could increase the right prerequisites for leadership.

Note. For all studies, the answer to ""**Is a qualitative methodology appropriate?"** is Yes. This would typically be a column in the CASP but for visual presentation purposes it has been removed as a column and stated here.

While the CASP provides a structured and accessible framework for assessing qualitative research, it can be rigid and lacks engagement with key qualitative concepts. Compared to the Evaluation Tool for Qualitative Studies (ETQS) and the Joanna Briggs Institute tool, CASP is less sensitive in assessing validity and offers limited guidance on interpreting its criteria (Hannes et al., 2010). Although CASP prompts consideration of the researcher-participant relationship, it does not explicitly evaluate reflexivity, a crucial aspect of qualitative integrity (Berger, 2015). However, CASP guidance encourages users to justify their decisions and advises that if a study does not meet the first three criteria, its quality may be questionable (CASP, 2025). The tool's reliance on binary responses (Yes/No/Can't tell) may also oversimplify complex methodological considerations, failing to account for the contextual and interpretative nature of qualitative research. In this review, most studies received 'Yes' responses, even when reporting on quality factors was limited. However, selecting 'Can't tell' would not have been appropriate, as incomplete reporting may reflect disciplinary or journal constraints rather than flaws in study conduct (Garside, 2014; Majid & Vanstone, 2018), thus the 'Yes' response was chosen for caution.

2.4.1 Quality evaluation of literature

All included studies had clear aims, ensuring their relevance to the research topic. Most utilised clinical leaders or executive managers with leadership responsibilities, though four studies included mixed samples of leaders and practitioners, making it unclear prior to full text review whether the focus was on receiving or enacting leadership (Burton et al., 2022; Edbrooke-Childs, 2019; Hean et al., 2017; Maguire et al., 2023). This made it difficult to separate findings from healthcare leaders and other leaders such as Lawyers (Hean et al., 2017). The full-text review confirmed that leaders constituted at least 40% of the sample in

studies where data was available, with a strong focus on leadership experiences. For instance, Hean et al. (2017) examined collaboration between leaders, while Burton et al. (2022) investigated the experiences of team leaders redeployed during the pandemic, although the exact number of redeployed participants was unspecified.

All studies employed appropriate sampling methods. 11 studies used forms of purposive sampling, including advertising (Burton et al., 2022), prior studied participants (Deveau & McGill., 2015), peer nomination (Ennis et al., 2016), and ward-based convenience sampling (Sundberg et al., 2021). Two studies described 'purposeful' sampling (Frawley et al., 2018; Maguire et al., 2023), though no distinction between 'purposeful' and 'purposive' sampling was inferred (Denscombe, 2017; Herchline, 2024). One study conducted secondary data analysis, acknowledging the original interviews were not designed for this research, though the questionnaire was deemed relevant (Edbrooke-Childs, 2019).

Ethically, 11 studies received formal ethics approval, addressing anonymity, confidentiality, and informed consent. Among the remaining three, one received service evaluation approval (Ebrahim, 2018), another stated adherence to ethical guidelines (McAllister et al., 2013), and the third was exempt from formal approval but followed ethical principles (Sundberg et al., 2021). None of the studies provided substantial details on debriefing or dissemination of findings. It is considered unlikely that participants experienced harm or distress from describing leadership experiences.

Qualitative techniques varied, with most using iterations of thematic analysis, followed by IPA, and grounded theory. IPA involves in-depth qualitative exploration, with sample sizes of 10 generally considered sufficient (Smith et al., 2022). However, Burton et al. (2022) conducted an IPA with 19 participants, acknowledging the relatively short interviews may have

limited the depth of analysis, making thematic analysis potentially more suitable (Braun & Clarke, 2019). Nordin et al. (2024) combined systematic text condensation with Normalization Process Theory to structure findings. Edbrooke-Childs (2019) employed framework analysis before thematic analysis to organise the data, an appropriate strategy given the large sample of 49 transcripts.

The Consolidated Criteria for Reporting Qualitative Research (COREQ) 32-item checklist was designed to enhance the transparency, reproducibility and rigour of qualitative research by ensuring sufficient detail is provided on study design, data collection, and analysis (Tong et al., 2007). Five studies adopted the COREQ (Burton et al., 2022; Maguire et al., 2023; Nordin et al., 2022; Nordin et al., 2024; Oates et al., 2020). While not essential, the eight remaining studies collecting primary data could have benefited from its use to ensure comprehensive reporting.

Only four studies explicitly addressed the researcher-participant relationship. Deveau & Rickard (2024) and Hean et al. (2017) used reflective diaries to mitigate researcher bias, with Deveau & Rickard (2024) also incorporating research supervision. Maguire et al. (2023) reviewed themes with the research team. Sundberg et al. (2020) adopted bracketing and reflective practice to minimise preconceptions and maintain curiosity.

Within IPA, interpretation of participants' lived experiences must account for the researcher's influence (Smith et al., 2022). However, both IPA studies (Deveau & McGill, 2015; Nordin et al., 2022) lacked explicit evidence of researcher reflexivity. Nordin et al. (2022) acknowledged the first author's prior senior role in the clinics but stated that two other researchers monitored for bias without detecting any. Ebrahim (2018) noted a vested interest

in the leadership role under examination, which may have influenced the final quotes chosen, but did not specify how this was managed.

Several studies employed strategies to enhance rigour. Edbrooke-Childs (2019) used research assistants unfamiliar with the service and achieved high coder agreement. Nordin et al. (2024) and Oates et al. (2020) engaged multiple researchers in coding but provided limited methodological detail. Ennis et al. (2016) used memo writing to ensure themes were grounded in the data. Burton et al. (2022) mitigated potential bias by ensuring interviewers had no prior relationships with participants. In contrast, Frawley et al. (2018) and McAllister et al. (2013) did not discuss researcher reflexivity.

Despite these variations, all studies presented clear statements of findings aligned with their research aims, context, and analytical approach, typically identifying key themes or theories.

2.5 Synthesis of literature review findings

This review used thematic synthesis (Thomas & Harden, 2008) to integrate findings from 14 studies that sought to answer:

What is currently known about leadership experiences of mental health professionals in the settings in which they work?

The process involved familiarisation with each paper, coding of results sections, and the development of overarching and analytical themes to generate new insights. The synthesis aimed to identify key themes, explore points of convergence and divergence, and deepen understanding of leadership experiences in mental health services. Five themes were identified and outlined in Table 9.

Table 9

Summary of themes from thematic synthesis

Theme
Theme 1: Systemic inefficiencies and constraints
Theme 2: Person centred leadership as a foundation
Theme 3: Navigating ambiguity and uncertainty
Theme 4: Role modelling as core leadership practice
Theme 5: Emotional demands of leadership

2.5.1 Systemic inefficiencies and constraints

Leaders experienced systemic inefficiencies and constraints such as organisational structures that hindered decision-making, resource tensions, overwhelming administration, and time pressures that compromised operational effectiveness and care quality.

Deveau & Rickard (2024, p.16) identified that senior leadership and organisational structures felt disconnected in decision-making. One participant stated:

> *"…the other biggest challenges is like your CEOs, your directors and your bosses, all implementing making decisions… they don't always know the situation"*.

Another participant reflected:

> *"… the problem is, it comes from like 'the finance department have decided that'. But then, the HR department will decide something else*".

This divide between senior leadership and frontline managers appeared to lead to policies that were misaligned with operational realities in mental health settings. Nordin et al.

(2024) referenced the importance of organisational drivers (training, coaching, and system alignment), to support leaders in overcoming systemic barriers to support policy implementation efforts, or face sub-optimal outcomes.

Hean et al. (2017, p.21) reported system fragmentation causing inefficiency. One participant stated:

> *"The problem is that the welfare service is very divided. They often have one case manager in economy and one case manager in housing and one in drugs rehabilitation…. it's very difficult for us to find out who is doing what?".*

This fragmentation, coupled with conflicting priorities, hindered leaders' ability to gather information and progress care. Frawley et al. (2018) found that centralised recruitment processes hindered recruitment and selection for specific mental health posts, while Deveau & Rickard (2024) highlighted the inefficiency of training new staff only for them to leave.

Leaders also described inefficient time and resource allocation. Maguire et al. (2023) reported one nurse spent approximately 80% of their time on managerial tasks despite their clinical expertise being most valued. Similarly, Deveau & Rickard (2024) noted managers in intellectual disability services reported "*administration is about ninety percent*" of their role. One participant from their study (p.16) questioned repetitive reporting practices:

> *"there's audit after audit. And when we've done the audit, we do an audit on the audit…. What are you going to do with the information? Goes up there somewhere but what's produced? I've never seen what's produced".*

Duplication directly impacted leaders' ability to engage in core practice leadership activities such as modelling, coaching, and providing feedback. One participant in Deveau & Mcgill (2015, p. 272) stated:

"… admin is a chore …. I did a piece of work that has to go on 26 different bits of paper".

There was a sentiment that leaders prefer to focus on clinical leadership instead of non-clinical responsibilities.

Across multiple mental health settings, time pressures emerged as source of constraint. In psychiatric services (Sundberg et al., 2021), leaders struggled to manage caseloads. One participant acknowledged:

"I don't keep track of them [patients] *at all… how then can I lead any psychiatric nursing care?"*.

Hean et al. (2017, p.21) reported logistical inertia between correctional services and mental health services. One participant stated:

"They had all sorts of excuses. They didn't have time. It was inconvenient".

Ethical decision-making was also compromised. During the pandemic, one participant in Burton et al. (2022) felt forced to deliver condensed care, straining relational support:

"… they went in, did whatever they had to do and got out as quick as they can".

This could be seen as efficiency, though also indicates systemic strain. Another participant discussed how a lack of inpatient capacity left them managing high-risk patients inappropriately within the community, increasing staff stress and service risk. In forensic

contexts, tensions between therapeutic and security priorities further hindered efficiency (Maguire et al., 2023).

Meanwhile, Edbrooke-Childs (2019, p.173) highlighted financial inconsistency within CAMHS services:

> *"…budgets are not consistent, services are always on the edge of vanishing, it's hard to … develop services when strategically you don't know whether you are going to exist"* (p.173).

Leaders faced challenges in planning service provision which impacts service delivery. These factors collectively point to systemic inefficiencies that obstruct safe, sustainable service delivery, along with collaboration across systems.

2.5.2 Person centred leadership as a foundation

Leadership in mental health settings was predominantly relational, marked by authenticity, collaboration, and inclusivity, though authoritarian approaches also emerged, particularly under organisational strain.

McAllister et al. (2013, p.661) found that authentic engagement was central to effective leadership, with mental health nurses having an ability to connect deeply:

> *"Something that mental health nurses do better than most is engage, and not just that superficial engagement, but actually really engage... if you're authentic with people... they reciprocate…. the danger … is that we can just play a role because you can".*

Maguire et al. (2023) suggested that collaborative engagement across all organisational levels must support change for change to succeed, with Edbrooke-Childs (2019, p.173) finding successful CAMHS transformation depends on leaders who actively engage staff at all levels with passion and transparency:

"You need support from managers and leadership, otherwise… you can't implement it in practice, which is frustrating".

Also, Nordin et al.'s (2024) observed that successful policy implementation leaders were more relational, emphasising trust and providing supportive environments for staff. Further, Ennis et al. (2016, p.356) found that an inclusive approach helped build staff confidence through intentionally supporting role modelling:

"… I'll always say, "Come and watch me do it and learn from others"".

Similarly, Ebrahim (2018, p.71) found inclusive practices where clinicians valued contributions from different professions. One participant stated:

"…80% of what we bring is the same but there's 20% that is different and we need to hold onto those differences because they are the bits that are important."

This extended to shared decision making:

"… If I was… slightly at odds with a colleague… those decisions were ones that were brokered and managed rather than imposed".

Similarly, Hean et al. (2017) found interdisciplinary teams relied upon collaborative practices, with Oates et al. (2020, p.3) describing how clinicians championed collaborative approaches over hierarchical models:

"… we need to have something which isn't hierarchy driven… everybody should have an equal means of contributing towards that discussion".

Another participant extended inclusivity to the patient:

"I always try to ensure that patients understand … everything is done within the context of the team, that it is not about me but it's about the team which includes the patient and their family".

These examples highlight how leaders include diverse professional perspectives and share power.

Nordin et al. (2022) identified three leadership themes among Norwegian frontline mental health leaders implementing clinical guidelines:

- "*Curious and welcoming*": Leaders emphasise openness to staff input and value diverse perspectives.
- "*Integrity and setting standards*": Leaders balance fidelity to guidelines with contextual adaptation.
- "*Caring and collegial*": Leaders prioritise team well-being and supportive environments.

They summarise adaptability was an essential skill leaders possess in navigating implementation challenges while maintaining staff relationships.

Burton et al. (2022, p.9) highlighted how collaboration helped teams remain resilient in the pandemic:

"We cover for each other… very resourceful, very resilient despite everything".

However, Burton et al. (2022, p.9) also documented how remote working disrupted collaboration, with one participant sharing:

> *"You actually miss that contact with your team members…. 'have I done that right, have I made the right decision' and you haven't got that so it does feel quite isolating"* (p.9).

This highlights collaboration fosters reassurance, reduces feelings of separation and provides decision-making support.

In contrast, several studies identified tensions where authoritarian leadership emerged. Burton et al. (2022, p.5) described rigid top-down management styles that excluded frontline staff during the pandemic:

> *"You're not being asked… you're just gonna do what we* [management] *say… there's no reasoning behind it".*

Another participant expressed frustration with exclusionary leadership practices:

> *"… decisions have been made, discussions have been had, we know nothing until something changes".*

Similarly, Frawley et al. (2018, p.991) reported that imposed performance targets often overlooked mental health contexts, reinforcing unhelpful hierarchies:

> *"The performance outcomes are probably not fully defined and not fully applicable to mental health settings. There's so much emphasis on financial management, so much emphasis on throughputs…".*

By excluding frontline staff from key decisions, top-down approaches can feel stressful, disconnected, and hierarchical approaches could create a culture of compliance rather than one of learning and continuous improvement.

Nordin et al. (2024) noted in Norwegian mental health services that directive strategies, administration and pure information sharing failed to secure meaningful engagement with clinical guidelines. Leaders relying solely on top-down controls were least effective. Likewise, Deveau & Rickard (2024) identified how hierarchical structures limited managers' capacity to engage directly with staff.

2.5.3 Navigating ambiguity and uncertainty

The third theme within the literature related to ambiguity permeating leadership experiences. Sundberg et al. (2021, p.738) found that Swedish psychiatric nurses often felt uncertain when formal leadership roles were unclear:

> *"I become nervous when the person who's supposed to lead doesn't clearly* [lead]*, then I become confused and want to take over so that someone leads. Then things can become a bit disorganised… what do I do then? I don't know."*

Sundberg et al. (2021) also found uncertainty stemmed from leadership competition and being newly appointed, compounding the challenges of decision-making. Maguire et al. (2023, p.1759) identified similar ambiguity for Nurse Unit Managers in forensic mental health settings, with a participant describing themselves as *"everything to everyone"* and there being a *"culture of not delegating".* Here, the nurse manager role lacked clear boundaries, leading to role strain and excessive workloads. Hean et al. (2017, p.21) found that the unclear

delegation of responsibility across national correctional and mental health services created dysfunction. One participant stated:

> *"*[It's] *to do with responsibility. No one is responsible. There are so many people and the responsibility is divided. Someone has responsibility for the mental health, someone for housing and they don't speak together"*.

This illustrates when leaders are managing complex demands across systems, locations, and professions, clear communication is essential for addressing ambiguity.

COVID-19 also intensified uncertainty. Burton et al. (2022, p.4) found that frequently changing guidance undermined leadership:

> *"We said… yes, it's safe to do group work and we told people this at lunch time and then the Prime Minister would deliver his briefing an hour later saying people are no long permitted to meet in groups... the very next morning we had to contradict our message… that undermined their confidence in us".*

Leaders found themselves relaying information that quickly became obsolete, eroding staff trust. Another participant reported it was *"quite difficult"* to keep up with the ever-changing guidance.

In response to ambiguity, Ennis et al. (2016, p.356) highlighted the importance of adaptability, with one participant describing:

> *"I think we're chameleons. I think I'm different with every person I meet".*

Similarly, one leader in Nordin et al. (2022, p.621) echoed this sentiment:

"I think of myself as plastic in a way, that you cannot sit and wait to enter smooth waters…. handling the boat in the waves…. navigate even with breakers around you".

These reflections depict effective leadership as dynamic and fluid, adapting to complexity rather than resisting it.

However, when constant change lacks clarity, adaptability and decision- making can be strained. At a strategic level, Frawley et al. (2018, p.990) observed how change initiatives often overlooked the operational realities and practicalities that frontline leaders face. One participant stated:

"… I was very clear who I reported to and who I needed… to get decisions either supported or if I wanted to bring around any service change. Everything then went centralised…. Decision making was pulled to the centre and it became diffuse. Who was responsible?".

Centralised decision-making that intended to streamline processes, instead created more uncertainty and hindered effective action.

2.5.4 Role Modelling as core leadership practice

Role modelling emerged as a frequent leadership behaviour across studies, shaping staff development, service quality, and organisational culture. This encompassed both intentional demonstration and unconscious modelling of professional etiquette. Ennis et al. (2016) identified a three-stage process of "intentional modelling" through which mental health nurses develop clinical leadership attributes. First, emerging leaders observe the desired leadership traits in others. Second, they reflect and adapt these behaviours to align

with their values. Third, they intentionally model these traits to others. One participant reflected:

> *"I've seen people who are so amazingly good at doing something but they do it in a way that I wouldn't be comfortable with, so you can try different people's skills out in a way but… it has to still sit good with you, because you can't pretend to be somebody you're not"* (Ennis et al., 2016 p.356).

This highlights how leadership development maintains authenticity while developing skills, with Mcallister et al. (2013) also emphasising authenticity in leadership. Another participant (Ennis et al., 2016, p.356) also described how role modelling was important in high pressure situations:

> *"I think, portraying to people around me, that I've got it under control… I can do it in a way, that, there's no stress and it's all right. And, even though it is a stressful situation, we look at it and prioritise"*.

These reflections illustrate leaders consciously managing their outward presentation projecting calm and control, even when leaders feel uncertain, builds trust among staff and service users. Leadership presence appears to be a skill that is actively developed.

Deveau & Mcgill (2015) and Deveau & Rickard (2024) examined role modelling through "practice leadership" in learning disability services and care homes. Practice leadership is an emerging evidence-based approach to developing good staff practice, improving the quality of life for people with learning disabilities (Deveau & Rickard, 2024). The approach emphasises empowering staff to deliver person-centered care over organisational convenience, with frontline leaders modelling best practices, observing staff, and giving regular feedback

regarding service user quality of life (Deveau & Rickard, 2024). Deveau & McGill (2015, p.271) found peer modelling was encouraged to build confidence, with one participant explaining:

> *"… I will sort of direct staff, especially new staff. I will say, 'watch so and so for supporting* [service user] *when he's upset because he's really good, or listen to* [staff member] *when he communicates with* [service user] *and try and emulate that and get that into your own practice"*.

This active approach to modelling helped staff internalise desired behaviours and understand concrete applications of person-centered care. Another manager described (p.269):

> *"*[I] *observe… my ears are open, and there's not a lot of things I miss really, and staff are quite surprised when I talk about things they are doing well… or not so well"* .

Here, some managers emphasised observant, pro-active intervention, rather than waiting for formal reviews. Deveau & Rickard (2024, p.18) also found that effective leaders remained *"hands on",* addressing performance in real-time rather than a detached, administrative stance:

> *"I can't confront the team unless I know my facts and I can't just go in there all guns blazing, like 'ooh, she's a Clipboard manager', 'cause I'm quite hands on".*

Another participant noted the importance of courage in confronting poor practice:

> *"I kind of just do what I think is, is right, I'll just have to put my big girl pants on and just deal with it"* (p.18).

These findings show that role modelling involves both demonstrating quality care and addressing unacceptable behaviours, requiring presence and emotional resilience. This may also highlight the challenge of balancing staff autonomy with maintaining quality care.

From a different angle, Nordin et al. (2022, p.623) found that leaders approached resistance with a *"curious and welcoming*" approach. Some staff used empathy and perspective-taking to respond to reluctance, with one participant sharing:

> *"I've reflected on that beforehand. Tried to ... understand their starting point. What makes the resistance strong? What makes them feel personally attacked? What can be done to avoid triggering it?".*

Another participant employed problem-focused approaches such as de-escalation or taking time-out to reflect collaboratively, supporting a non-confrontational by accountable leadership style. Overall, leaders within mental health settings role model to shape values and culture, and to also carry themselves, projecting confidence, empathy, and integrity in difficult moments.

2.5.5 Emotional demands of Leadership

Leaders in mental health settings displayed emotional effort, both in managing their own emotional responses and supporting others through challenging circumstances. Ennis et al. (2016, p.356) found that mental health nurse leaders consciously regulated their emotions despite feeling overwhelmed internally, as one participant described:

> *"If somebody's really aggro I-I look quite comfortable … people behind me very comfortable with me doing the talking, but the person is so aggro, I'm screaming in*

my head would somebody grab him before he decks me, but because I look comfortable it- it continues really."

This illustrates the invisible emotional effort in projecting calmness to maintain confidence in challenging situations. Oates et al. (2020, p.4) found that Responsible Clinicians emphasised "*being present*" during difficult interventions, as one participant stated:

"If someone is… given medication against their will I would like to [be there]*,… I'm not actually present with him, giving the injection, I want to be there… to support the team as much as anyone, the patient might not want to talk to me, but I want the team to know that I'm available".*

Visibility served both a supportive and symbolic function. Oates et al. (2020, p.3) also reported that leaders felt the *"gravity", "privilege"*, and *"weight"* of critical decisions about patient risk, leave, discharge, and treatment. One participant shared:

"I decide that you get locked up for six months. I decide whether you get to go home. I decide that you are going to be forced to take some horrible medication... These are pretty horrible things to do… you've got to retain that sense of perspective...".

Another participant reflected on how confidence builds over time (p.3):

"I'm probably making decisions now that I'd have been absolutely terrified to make a few years ago, but I feel a lot more confident in my knowledge and what I'm doing now…".

These reflections capture the moral weight of leadership decisions and aiming to remain connected to staff and service users, with the growing assurance that comes with experience.

Building on this, McAllister et al. (2013, p.661) shared a powerful moment of emotional connection. A nurse leader recalled:

> *"… therapeutic intervention to make him feel better, but I just couldn't. Nothing I could say is going to make this better. I just put my hand on his shoulder and we were both crying. And people might say, "Well that's wrong, you're losing your boundaries" or whatever. But I felt all I could do was share his despair at that time and maybe be a container for it".*

This illustrates how leaders can prioritise human connection, even if it blurs traditional professional boundaries.

Emotional strain also arose from frustrations with staff. Sundberg et al. (2021, p.738) noted the moral distress caused when leaders encountered staff disengagement:

> *"Unwillingness is also a difficulty, when it's pure unwillingness. There's no willingness to work, people who are just sitting there, who don't want to be there, that's almost the worst thing, because you can't do anything more about that".*

Also reporting similar frustrations, Maguire et al. (2023, p.1760) highlighted how staff were deterred from the nurse manager role in forensic settings. One participant stated *"it was a stressful job*" so did not apply, with another participant commenting:

> *"… a lot of them* [nurse unit managers] *respond to work emails outside working hours and I am like, I don't want to do this. That is why I haven't applied for the job".*

Expectations of constant availability increased emotional strain and discouraged candidates from applying for leadership positions. Despite pressure, some leaders developed

coping mechanisms. Nordin et al. (2022) referenced self-care and peer support, with leaders relying on trusted colleagues during implementation stresses. Additionally, McAllister et al. (2013, p.662) identified humour as both a therapeutic and resilience tool. One participant stated:

> *"Humour is useful in defusing situations. I just think there's humour in everything... So it's just an attitude of mind, I think. And it helps in team building and team morale".*

Humour helped to maintain perspective and strengthen team cohesion. Overall, the emotional demands on leaders in mental health settings encompass moral complexity, boundary negotiation, and a sustained presence during distress.

2.6 Discussion and Clinical Implications

This thematic synthesis examined 14 qualitative research studies published between 2013 and 2024, exploring leadership experiences across diverse mental health settings. Studies spanned Westernised countries, professional disciplines (nurses, psychologists, social workers, occupational therapists, and managers), and varied contexts (forensic, care home, inpatient, CAMHS, CMHTs). The findings offer insights into systemic challenges, relational versus authoritarian leadership, navigating ambiguity and uncertainty, role modelling, and emotional demands, each carrying implications for practice.

First, systemic constraints were consistently found to undermine leadership. Resource limitations such as high caseloads, staff shortages, and unstable budgets left leaders struggling to maintain safety and service quality (Edbrooke-Childs, 2019; Frawley et al., 2018; Sundberg et al., 2021). Leadership effectiveness was further eroded when decisions were made by management at a distance from frontline realities (Deveau & Rickard, 2024; Hean et al., 2017).

Excessive administrative demands also diverted leaders from clinical priorities (Maguire et al., 2023; Deveau & McGill, 2015). Clinically, these highlight the need to streamline bureaucracy, ensure local decision-making autonomy, and stabilise the workforce. Aligning operational and strategic leadership is critical to support leaders delivering effective, relationship-focused mental health care.

Secondly, relational leadership styles marked by authenticity, collaboration and equitable decision-making were received well across diverse mental healthcare settings (Edbrooke-Childs, 2019; Ennis et al., 2016; Hean et al., 2017; Maguire et al., 2023; McAllister et al., 2013; Nordin et al., 2022; Oates et al., 2020). Conversely, authoritarian leadership created disconnect and dissatisfaction (Burton et al., 2022; Deveau & Rickard, 2024; Frawley et al., 2018; Nordin et al., 2024). Clinically, these findings support the prioritisation of emotionally intelligent, inclusive leadership that centres shared power, and co-production, and collective problem solving to improve care quality and staff retention.

Third, ambiguity and uncertainty were central to leadership experiences. Unclear roles, blurred responsibilities, and competing organisational demands contributed to confusion, stressed and reduced confidence among leaders and teams (Maguire et al., 2023; Sundberg et al., 2021;). During crises like COVID-19, rapidly shifting guidance further eroded trust in leadership (Burton et al., 2022). While adaptability emerged as a key trait (Nordin et al., 2022), it was not enough without systemic clarity and effective communication. Clinically, this underscores the need for clearly defined roles, strengthened inter-agency coordination, and decentralised, context-sensitive decision-making. Supporting leaders systemic clarity is essential to reduce role strain and ensure responsive, high-quality care.

Fourth, Leaders shape organisational culture through actions rather than directives. Leaders built trust and stability by demonstrating authenticity, being visible in clinical work, and offering real-time feedback (Ennis et al., 2016; Deveau & Rickard, 2024; McAllister et al., 2013). In care homes and learning disability services, practice leadership involved modelling person-centred care, reinforcing best practice, and balancing staff autonomy with accountability (Deveau & McGill, 2015; Deveau & Rickard, 2024). Clinically, fostering leadership presence through role modelling can help develop a supportive environment for staff to deliver high quality care.

Fifth, leaders in mental health settings face significant emotional demands, balancing their emotions with supporting others in challenging situations (Ennis et al., 2016). Oates et al. (2020) highlighted the moral weight of high-stakes decision-making, such as involuntary treatment and risk where leaders require resilience and perspective. Leaders also confront emotional challenges such as frustrations with disengaged team members (Maguire et al., 2023; Sundberg et al., 2021). Coping strategies such as self-regulation, humour, and peer support (McAllister et al., 2013; Nordin et al., 2022;) help normalise emotions fostering resilience and emotional well-being.

2.7 Limitations

This thematic synthesis has several limitations that should be considered when interpreting the findings. First, the study only focused on qualitative papers, potentially missing additional studies regarding leadership experiences in mental health settings. Second, although the included studies predominantly represent Western healthcare contexts, there was great variability in the context of the studies, from operational remit, strategic remit,

collaboration, and evidence-based practice implementation. Thus although a wide variety of themes were found, majority agreement on themes between studies was limited.

Methodologically, most studies relied on self-reported data through interviews. This reliance on self-report potentially introduces demand characteristics, particularly when discussing sensitive aspects of leadership practice. Additionally, included studies appeared to utilise management and leadership interchangeably. Two studies were in intellectual disability settings, and it was assumed that there would be overlap with mental health needs, and it was out of scope for the researcher to contact the authors to confirm if service users also had mental health conditions.

Finally, the synthesis itself involves interpretative decisions that may prioritise certain perspectives over others, potentially oversimplifying the complex relationship between leadership approaches and specific organisational contexts.

2.8 Gaps in the SLR

This review identifies several gaps in research on leadership within mental health settings. Firstly, there is a scarcity of empirical studies exploring the lived experiences of leaders; many excluded articles were theoretical, reflective, or policy-focused, leaving a gap in understanding what it means to enact leadership in practice.

Secondly, leadership research remains disproportionately focused on mental health nurses, with limited representation of clinical psychologists. Despite their senior roles within UK services, psychologists are under-researched in this area. Given the multidisciplinary nature of modern mental healthcare, more research is needed into how various professional groups, including psychologists, occupational therapists, and social workers, experience and enact leadership given their distinct training and input.

Thirdly, there is little exploration of how leaders navigate the complexities of clinical leadership, which is often discussed interchangeably with management. The distinct but overlapping roles of clinical and managerial leadership require more detailed examination, particularly in mental health contexts. For example, allocating budgets and developing a service are different to shaping organisational culture and supporting staff wellbeing.

Finally, despite its growing prominence in UK healthcare policy and practice, compassionate leadership was not explicitly examined in any of the included studies. This presents a significant gap, particularly given the recognised importance of relational approaches in mental health leadership post-COVID-19.

2.9 Rationale for the current study

While studies in this SLR have highlighted relational and inclusive leadership in mental health settings, none specifically address compassionate leadership, and minimally involve clinical psychologists. As the introduction summarised (section 1.8), current insights into compassionate leadership mainly draw on top-down H&SC frameworks, with limited research studies in mental healthcare leadership. A recent systematic review explored healthcare leaders' experiences with compassionate leadership, but lacked focus on mental health roles (Östergård et al., 2023). This highlights a critical gap in understanding how compassionate leadership is enacted in mental health services, particularly by clinical psychologists who are underutilised in healthcare leadership research. This study aims to narrow this gap by exploring how clinical psychologists enact compassionate leadership in mental health settings, contributing to contemporary mental health leadership research.

3.0 Method

3.1 Chapter Overview

This chapter describes the research question, aims, and methodology used within this research. This will include the motivation for the study design, the rationale for the use of IPA, its theoretical underpinnings, and epistemological relevancy. The recruitment of participants, ethical considerations, and an overview of data collection and analysis methods will also be summarised.

3.1.1 Research aim and question

The gap in research and professional application is stated in section 1.8, with section 2.8 highlighting the gap in the SLR and 2.9 providing rationale. The research aim is to explore the experience of clinical psychologists enacting compassionate leadership in H&SC settings. The research question is therefore:

How do clinical psychologists experience the enactment of compassionate leadership within the setting they practice in?

Enactment, what leaders do, is the central phenomenon, rather than the receipt of compassion.

3.1.2 Briefly revisiting epistemology

As summarised in section 1.2.4, this study adopts a critical realist epistemology. In the context of the method, a critical realist epistemology can shed light on the underlying structures and mechanisms (Roberts, 2014) that influence compassionate leadership. This lens supports exploration of deeper unobservable influences on compassionate leadership, such as leaders' personal experiences, traits, system culture, and socio-economic conditions.

Exploring these mechanisms with leaders could inform how compassionate leadership is enacted. Critical realism would posit that compassionate leadership is not universally fixed; it is context-dependent and shaped by cultural norms, relational dynamics, and structural forces. CPs will bring their own sociocultural contexts which are shaped by their own social graces (Burnham, 2018), with compassionate leadership emerging with nuance depending on the intersecting structures and power dynamics within mental health and H&SC systems.

3.2 A qualitative approach: Interpretative Phenomenological Analysis (IPA)

The research questions allowed for breadth as it facilitated exploration of areas of interest without assuming specific outcomes. Compassionate leadership is a nuanced phenomenon, and a qualitative approach was chosen to elicit rich, detailed accounts of participants' subjective experiences to allow for meaning making to be captured, with these unique insights often overlooked in quantitative research (Mohajan, 2018; Padgett, 2016).

Interpretative Phenomenological Analysis (IPA) was chosen as the most appropriate qualitative method, as it specifically invites participants to offer a rich, detailed, first-person account of their experiences (Eatough & Smith, 2017). IPA is an ideal method for this research, as it is grounded in recognising that individuals' experiences are shaped by interacting with their environmental, cultural, and social context. These factors are core when examining how clinical psychologists (CPs) understand and enact compassionate leadership in health and social care settings. IPA is rooted in three main philosophical traditions: phenomenology, hermeneutics, and idiography (Smith et al., 2022), and these serve as reasons as to why IPA is preferred over other qualitative methods. A summary of these traditions follows to justify the suitability of IPA for this study.

3.2.1 Idiography

Rather than seek broad generalisations, IPA is particularly concerned with the detailed exploration of how individuals make sense of their personal experiences, recognising that each person's psychological, social, and professional context contributes to the distinctiveness of their experience (Eatough & Smith, 2017). This idiographic focus aligns closely with the aims of this study, which seeks to explore the lived experiences of CPs who self-identify as enacting compassionate leadership. Given that compassionate leadership within CP is an underexplored area, an idiographic approach offers an opportunity to capture the rich, nuanced, context-dependent experiences of a small, purposefully selected group of participants. This study focuses on those who not only value compassion in leadership but who believe they have actively enacted this leadership style. By examining these individuals' unique perspectives, the idiographic method allows for a deep understanding of how compassionate leadership is enacted within CP, and could provide unexpected responses generating new insights for existing theory and research (Noon, 2018). CPs are trained to practice with self-awareness and emphasise collaborative practice, which may contribute to a reluctance among some CPs to explicitly identify as leaders, if it historically associated with assertiveness or hierarchical authority. However, the idiographic approach is well-suited to this context, as it prioritises in-depth, qualitative analysis of a self-identifying sample of whom compassion is central to their leadership. Through detailed examination of individual experiences, this study aims to generate rich, meaningful insights that reflect the complexity of enacting compassionate leadership in CP.

3.2.2 Phenomenology

Phenomenology serves as a foundational pillar within IPA, allowing for an in-depth exploration of lived experiences and the meanings individuals ascribe to them. This study aims to investigate the experiences of CPs who identify as compassionate leaders, utilising phenomenological principles to uncover the nuances of their lived experiences in this role. Phenomenology focuses on subjectivity, therefore, this research seeks to understand how CPs enact compassionate leadership whilst holding in mind their historical, social, linguistic and cultural contexts (Larkin et al., 2019). Thus, meaning making is one of perspective and cannot be detached from the intersection of real-world phenomena.

In the early 20th century, philosopher Edmund Husserl founded phenomenology, and introduced the concept of "intentionality", which posits that consciousness is always directed toward something, thus shaping our understanding of experiences (Christensen et al., 2017). In this study, the intentional focus on enacting compassionate leadership enables a detailed examination of how CPs make sense of this enactment. Husserl also referred to "bracketing", which is the process of suspending one's own preconceptions, assumptions, and biases about the external world or the phenomenon being studied. Husserl believed that to truly understand the essence of an experience, researchers must "bracket" their preconceived notions and approach the experience in a fresh, unprejudiced manner. This allows the researcher to focus purely on the lived experience of the participants, without being influenced by prior beliefs or knowledge (Dörfler & Stierand, 2021). Bracketing would facilitate access to rich qualitative data emerging from participants' reflections of enacting compassionate leadership.

In addition to Husserl's insights, Martin Heidegger was a later phenomenologist who emphasised the significance of context, temporality, and the situated nature of existence (Smith et al., 2022). Heidegger's notion of "Dasein", or being-in-the-world, highlights the importance of understanding CPs experiences within their professional and social contexts. By situating compassionate leadership within the specific challenges and dynamics faced by CPs, this research recognises the interplay between personal beliefs and environmental factors, enriching the phenomenological analysis.

3.2.3 Hermeneutics

Hermeneutics plays a crucial role in IPA as it is concerned with the interpretation of lived experiences, particularly how individuals make sense of their world, and is important to consider in leadership philosophy (Cunliffe & Hibert, 2016). In this study, hermeneutics is employed at two levels. First, participants engage in a process of self-interpretation, as they reflect on their experiences of compassionate leadership and make sense of their leadership actions within the context of their professional roles, values, and interpersonal relationships. Second, the researcher interprets the participants' accounts, engaging in a dynamic, iterative process of understanding. This is known as the "hermeneutic circle" and refers to the process by which understanding is developed iteratively between the part and the whole: to understand the whole experience, one must consider the individual parts, and vice versa (Smith et al., 2022).

As the researcher has undergone formal healthcare leadership training with a focus on person-centred leadership principles, this background adds depth to the interpretation of participants' accounts. The interpretative process not only involves understanding the participants' perspectives but also integrating the researcher's own experience, while

ensuring a reflective and balanced approach. This allows for a more profound understanding of how compassionate leadership is enacted in CP.

The hermeneutic circle is particularly relevant here because the researcher must continuously move between interpreting individual segments of data (specific examples of compassionate leadership behaviours) and the overall meaning of compassionate leadership as a practise in the lives of CPs. This is line with philosopher Hans-Georg Gadamer's position on learning such that intersubjective inquiry occurs through both diachronic (between ourselves and text) and synchronic (between ourselves and another) dimensions (Raelin, 2016, p. 10). Each iteration deepens the understanding of how compassionate leadership is enacted, allowing for richer, more nuanced insights.

3.2.4 Consideration of other approaches

Qualitative methodologies are frequently employed to explore lived experience, with IPA methodologies focusing on how individuals make sense of their experiences through subjective interpretation. This aligns with the core goals of CP, where understanding personal narratives is crucial to making sense of psychological experiences. An alternative method considered was discourse analysis, which examines how language constructs social realities and identities (Taylor, 2013). While discourse analysis offers insights into the social context of experiences, it is not idiographic in nature. Discursive research focuses on understanding psychological topics without claims about internal mental processes or how individuals respond to external distinct social world (McVittie & Mckinlay, 2023). For the topic of compassionate leadership, discourse analysis could offer insights into how language fosters a culture of open communication (Östergård et al., 2023), it would prioritise the social implications of language over the personal significance of individual experiences.

Grounded theory is another valuable approach for generating theories from data, but often prioritising the development of theoretical frameworks over the exploration of individual experiences (Creswell & Poth, 2016). This may lead to a more generalised understanding of compassionate leadership, potentially overlooking the emotional depth and personal meaning behind compassionate leadership experiences. Additionally, grounded theory's constructivist and positivist epistemological underpinnings (Charmaz, 2017) do not align with the critical realist lens of this study (Bhaskar, 2013), which is consistent with IPA's focus on making sense of lived experiences. Therefore, for this study, an IPA methodology is preferred to discursive, grounded theory, and other qualitative approaches.

3.3 Stakeholder Consultation

Consulting CPs who self-identified as compassionate leaders was crucial for grounding this research in real-world application. This approach provided an authentic perspective not yet fully captured by academic research, grounding the study in practical realities and increasing its relevance for clinical practice. While compassionate leadership benefits both patients and professionals, this study focused on staff as Experts by Experience (EbEs), as their professional insights were most relevant to the leadership context. Consulting patients would be more appropriate for a study focused on how compassionate leadership affects patient outcomes.

Stakeholder consultation in this study occurred in two phases. First, a senior CP working in H&SC who self-identified as a compassionate leader, provided feedback on materials such as the project title, information sheet, consent form, and the use of a compassionate leadership questionnaire. They queried the use of a strict cut-off score on the questionnaire, as this could be exclusionary or invalidate participants' self-perception

compassionate leadership. Subsequently, how would the researcher inform the participant of this outcome, particularly if a participant felt they strongly identify with the compassionate leadership. Consequently, the inclusion criteria (section 3.5.1) was refined to allow participants to use the compassionate leadership questionnaire reflectively rather than with a discrete cut off. This approach promoted a more compassionate and inclusive recruitment process.

The second phase of stakeholder consultation were the participants themselves who were positioned as EbE's. Traditionally, EbEs are patients or service users; however, this study extends the concept to include professionals with lived experience of enacting leadership (Beresford, 2005). CPs who self-identify as compassionate leaders have lived experience of leadership, which offers critical insights within the phenomenon, and so extends the concept of EbEs to leadership (Byrne et al., 2018). CPs reflecting on their compassionate leadership practice are well-placed to inform the research. The IPA methodology supports this reflective engagement, aligning with the profession's emphasis on reflective practice (BPS, 2019), and enabling participants to critically explore their leadership experiences within the evolving landscape of H&SC (DCP, 2021; White et al., 2019).

3.4 Ethical Approval

In discussions with the principal supervisor, the topic of enacting compassionate leadership was considered low-risk due to the positive connotation of compassionate leadership, and the professional background of participants. CPs are trained to engage in reflective conversations and practice safely within their competence. The study does not explicitly address distressing clinical experiences, though participants may reference them from a leadership perspective. In the unlikely event of emotional upset, participants would be

signposted to their employer's employee assistance programs, workplace supervision, and peer support groups. Given the nature of inquiry regarded leadership experience and the participants' professional expertise, no formal risk assessment was deemed necessary. NHS ethical approval was not required, as the researcher did not contact staff through direct NHS channels, such as in-person recruitment in NHS settings or initiating contact via NHS email. Further, the researcher wished to include CPs working in the broader H&SC system which includes settings out of the NHS such as local authorities and charities, as CPs increasingly work in these settings. Standard ethical approval was granted by the University of Hertfordshire's Health, Science, Engineering and Technology Ethics Committee (Protocol number LMS/PGR/UH/05613; Appendix 2). The research was conducted in accordance with the BPS research ethics and online data collection guidance (BPS, 2021a, 2021b).

3.4.1 Informed Consent

In line with BPS guidelines (BPS, 2021a) prospective participants were emailed a participant information sheet (PIS; Appendix 3) which provided them with information relating to the aims, risks, benefits, and time commitment, should they decide to take part in the study. All participants were offered a chance to ask any questions ahead of their participation. Participants were also informed of their right to withdraw at any point, and limits to data withdrawal as once data was anonymised and analysed it would not be possible to withdraw this information. Prospective participants were asked for explicit written consent and were asked to return a signed consent form (Appendix 4).

3.4.2 Confidentiality and data protection

Prospective participants were informed about the confidentiality of their data via the PIS, consent form, and prior to data collection. Any identifiable data provided would be

anonymised. For example, pseudonym names would be used for any quotes provided, services would be referred to in general terms (e.g. 'an adult service' instead of 'Hertfordshire Hospital NHS Trust'), and any unique examples given would be generalised with the essence maintained (e.g. 'leading a specialised healthcare pathway' instead of 'leading a dementia ward re-organisation'). Prospective participants were also informed that any confidential and identifiable information such as consent forms and collected data would be stored on the University of Hertfordshire Office 365 cloud drive. Access to the cloud drive was restricted to the lead researcher and principal supervisor, and safeguarded by password protection and multifactor authentication. Prospective participants were also informed that the data would be deleted once the research had passed as a condition of completing the doctorate degree.

3.5 Participants

IPA studies typically involve small, homogeneous participant samples, allowing for an in-depth exploration of both shared and unique experiences within the group (Smith et al., 2022). For this research, homogeneity was defined by participants' status as qualified CPs working in H&SC, as leadership is a standard responsibility within the public sector workforce for qualified CPs. A sample size of six to ten participants is typically recommended for professional doctorate IPA studies (Smith et al., 2022). Compassionate leadership is potentially shaped not only by professional role but also by intersecting aspects of identity, including culture, gender, spirituality, and lived experience. Therefore, within this bounded professional homogeneity, the study sought to recruit up to 12 participants, including advertising in a global majority network to allow for inclusive and representational scope, while still maintaining an idiographic commitment to case-by-case analysis.

3.5.1 Inclusion criteria

Compassion is recognised as a core value within healthcare, with the BPS, HCPC, and NHS highlighting its importance in leadership (DCP, 2021; HCPC, 2023b; NHS, 2023). While compassionate leadership can occur at all levels, this study focused on qualified CPs working in H&SC settings within the past 12 months. This group was selected due to their likely engagement with a range of leadership responsibilities, including recent experiences shaped by post-COVID opportunities, a period that heightened the call for compassionate leadership (Gotsis, 2023; NHS, 2023).

While many CPs may naturally align with the value of compassion given their role in alleviating distress, this study specifically sought participants who view compassion as central to their leadership identity. This focus aimed to support a rich and meaningful exploration of compassionate leadership as an integrated practice, not isolated compassionate acts. To aid prospective participants in reflecting on their alignment with compassionate leadership, they were provided with the Compassionate Leadership Self-Report Scale (Sansó et al., 2022), a 16-item Likert scale instrument rated from 'completely disagree' to 'completely agree' (Appendix 5). The scale measures four key behaviours; 'attending, 'understanding', 'empathising', and 'helping', and forms the foundation for compassionate leadership research through The King's Fund[7] (Atkins & Parker, 2012; Bailey & West, 2022a). Validated in a palliative care setting, this tool would be useful for organisations seeking to engage leaders in self-reflection on how compassion is demonstrated in their leadership (Rao et al., 2023b). Prospective participants were not required to return the questionnaire. It was intended solely as a reflective tool to

[7] The King's Fund is an independent charitable organisation working to improve health and care in England. They generate and share evidence, provide analysis and independent challenge, and help people make sense of the health and care system.

help them consider whether they strongly identified with compassionate leadership and wished to take part. Table 10 provides a summary of the inclusion criteria.

Table 10

Participant Inclusion Criteria

Inclusion Criteria
1. Qualified Clinical Psychologist, Band 7 or above, or public sector HS&C equivalent
2. Has worked in a public sector H&SC setting in the last 12 months
3. Self identifies as having experience of enacting compassionate leadership. To support self-identification, prospective participants will be provided with a validated self-report compassionate leadership scale (Sansó et al., 2022) to reflect on.

3.5.2 Participant recruitment

CPs are increasingly working across partner organisations beyond the NHS. Therefore, this study aimed to recruit CPs working in the H&SC sector which includes local authorities, charities, community centres, and the NHS. The study was promoted through four recruitment strategies what all utilised the recruitment poster (Appendix 6). First, the study was advertised on the professional networking site, LinkedIn, and a WhatsApp forum for global majority CPs. Secondly, a CP employed by a local authority distributed the study within their network. Third, purposive sampling was employed by the lead researcher directly contacting local authorities and charities via email to identify CPs who may want to participate. Finally, snowball sampling was utilised, as participants voluntarily enquired about sharing the study with peers. 11 CPs expressed interest in participating, and all were sent the PIS (Appendix 3), consent form (Appendix 4), reflective tool (Appendix 5), and a reminder they were able to ask questions

about the study. If no response was received after seven calendar days, a follow-up email was sent.

3.5.3 Participant Information

Eight participants returned their signed consent forms after the first follow up. An additional potential participant explained they intended to respond in due course. However, in line with the inclusion criteria, the researcher did not follow up again to avoid any coercion. It was important that participants felt strongly enough about compassionate leadership to prioritise voluntary involvement. Table 11 summarises the participants information, with names pseudonymised, and their service generalised.

Table 11

Participant demographics

Pseudonym name	Title	Service	Qualified experience	Gender	Ethnicity
Liana	Clinical Lead	Children's social care	< 5 years	Female	East Asian British
Jamie	Clinical Psychologist	Fostering Services	< 5 years	Female	White British
Sonia	Consultant Clinical Psychologist	Adult community mental health	> 15 years	Female	Middle eastern
Maria	Consultant Clinical Psychologist	Inpatient Services	>15 years	Female	South Asian
Lola	Clinical lead	Family Services	> 15 years	Female	Black British African Caribbean
Anjali	Clinical lead	Children's Safeguarding	> 10 years	Female	British South Asian
Michaela	Clinical lead	Adult Safeguarding	> 15 years	Female	White British
Amir	Clinical Psychologist	Adult community mental health	>5 years	Male	South Asian British

Participants were based across regions of England and worked in seven distinct settings within the NHS and local authorities. According to HCPC diversity data, 85% of CPs in the UK identify as White, with 5% identifying as Asian, 1% as Black, and 2% as belonging to other ethnic groups (HCPC, 2023a). In this study, two participants identified as White, while six were from global majority backgrounds.

3.6 Interview Schedule

A semi-structured interview allows for an in-depth, qualitative exploration of participants' experiences, offering flexibility to elicit detailed stories, thoughts, and feelings (Madill, 2012). This method aligns with the aim of investigating compassionate leadership by fostering a purposeful yet open-ended dialogue. Interviews were conducted online via MS Teams, and lasted no more than 80 minutes. In keeping with the principles of IPA, participants were encouraged to speak freely and reflect at length, allowing for the emergence of rich, nuanced, and contextually grounded accounts (Smith et al., 2022). This approach balanced structure with responsiveness, facilitating a focused yet participant-led exploration of how compassionate leadership is enacted. The interview schedule (Appendix 7) was developed by the primary researcher, and refined following consultation with the principal and secondary supervisors to ensure prompts were appropriately framed to support meaning-making.

3.7 Data Analysis

MS Teams interviews were recorded and automatically transcribed using the platform's transcription feature. After the interviews, the lead researcher reviewed the recordings alongside the automated transcriptions, correcting inaccuracies and cleaning formatting issues. By revisiting both the recordings and the transcription, the researcher

enhanced the reliability of the data and ensured consistency in preparation for data analysis. Figure 4 provides a summary of the steps taken in completing the IPA, informed by Smith et al. (2022).

[GAP TO NEXT PAGE]

Figure 4

Summary of IPA process (Smith et al., 2022)

Step		Process
1	Starting with the first case, reading and re-reading.	Immersion in the data ensuring the participant is the focus with active engagement with the data. Initial striking aspects of the data can be noted. Verbatim transcript is in the left margin.
2	Exploratory noting.	A line-by-line analysis of the transcript. In the middle margin, identifying any descriptive, linguistic, and conceptual comments. Identifying key phrases, language use, and objects of interest to the participant.
3	Constructing experiential statements.	Stemming from exploratory notes and relevant parts of the transcript. In the right margin, capturing experiential statements of the participant and the researcher's interpretation in a concise manner.
4	Searching for connections across experiential statements.	The focus is on grouping related statements together to form clusters of meaning. This involves identifying patterns between statements that help explain the participant's experience. A structure is developed that highlights the most significant aspects of the participant's account.
5	Naming personal experiential themes (PETS).	Each cluster of experiential statements is given a name that summarises its characteristics. This results in a table representing superordinate themes and subthemes.
6	Repeating the analysis.	Moving onto the next participant's data and repeating steps 1-5. Treating each case on its own terms in line with the idiographic approach.
7	Developing group experiential themes (GETS).	Analyse across all cases to identify points of convergence and divergence across PETS, creating shared insights and unique themes across participants.

Transcripts were transcribed using Microsoft 'Word', with exploratory notes and experiential statements organised within a table format (see Appendix 8 for an example). Experiential statements were labelled with the participant number and page number and transferred to a 'Word' document for concise participant summaries (see Appendix 9 for an example). Subsequently this was transferred to an 'Excel' spreadsheet to facilitate on-screen analysis. This method was selected due to its efficiency in developing themes and sub-themes for PETS while maintaining a robust audit trail (Smith et al., 2022, p. 99). Themes and subthemes for the PETS were systematically linked to experiential statements (see Appendix 10 for examples). 'Excel's' filtering function allowed the grouping and reviewing of experiential statements under themes and sub themes, facilitating a clearer view of each participant's meaning-making. (see Appendix 10 for an example).

Constructing PETs required iterative reflection, using a double hermeneutic stance to interpret participants' accounts while being mindful of my own sense-making as a researcher. I frequently returned to the original transcript to ensure experiential statements remained grounded in participants' words. This method was followed separately and independently for each participant. The PETS were put onto one page on 'Excel' and a process of clustering (Appendix 11), condensing, and renaming the emerging groups took place, while recalling that IPA is not concerned with presenting a 'group norm' but instead highlighting the shared and unique features of experiences of participants (Smith et et al., 2022, p.100). In developing GETS, the various PETS tables were crossed examined for patterns for convergence and divergence.

3.7.1 Reflexivity revisited

Reflexivity is central to IPA, which acknowledges the researcher's active and interpretative role in the research process (Smith et al., 2022). Rather than assuming neutrality, IPA invites critical self-awareness, requiring researchers to consider how their beliefs, experiences, and positionality may shape both data collection and interpretation (Lumsden, 2019).

Practising reflexivity enhances transparency and credibility, helping the researcher "bracket" (become aware of prior beliefs and knowledge) their assumptions and remain focused on participants' lived experiences (Berger, 2015; Dörfler & Stierand, 2021). Throughout the study, a reflective diary was maintained (Appendix 1) to "bracket" thoughts, reactions, and develop interpretations, supporting continuous reflexive engagement, reducing the influence of personal biases on data interpretation.

Supervision was a regular reflexive checkpoint. Regular input from the principal supervisor, and an external secondary supervisor unaffiliated with the research environment helped ensure critical distance. The principal supervisor reviewed exploratory noting and experiential statements for two participants and subjectively confirmed a high level of interpretive agreement. Both supervisors reviewed the draft themes and associated quotations, also reporting strong consensus on theme development and evidence.

This dual-supervisory process, combined with personal reflexivity, enhanced the rigour of interpretive decisions and contributed to the overall trustworthiness of the analysis.

3.8 Quality Appraisal

The CASP quality indicators (CASP, 2024) as described in the systematic review was consulted to achieve strong research quality, with the evaluation in Appendix 12. The present study is appraised using three IPA-specific quality frameworks: Smith's (2011) seven core features of high-quality IPA, Nizza et al.'s (2021) four markers of IPA excellence, and the use of group experiential theme (GET) frequency guidelines outlined by Smith et al. (2022, p. 105). Table 12, 13, and 14 provide the various appraisals.

Table 12

IPA specific quality appraisal (Smith, 2011)

Quality criteria	Quality appraisal
The paper should have a clear focus.	*Papers are likely to be considered higher quality if they provide detail of a particular aspect rather than having a broad focus.* • This research purposively recruited clinical psychologists specifically exploring their experience of enacting compassionate leadership. • The lead researcher remained focus on the topic through research supervision.
The paper will have strong data.	*The quality of the interview data obtained sets a cap on how good a paper can be.* • A semi-structured interview was employed to enable participants to explore the nuanced experiences without undue direction from the researcher. • Questions were reviewed by the research supervisors for refinement (Appendix 7) to elicit meaning-making rather than mere descriptions, supported by a compassionate leadership questionnaire to orient participants and ensure they identify with the enactment. • Interview technique was refined throughout the process, with a reflective diary used to address researcher bias.
The paper should be rigorous.	*The paper should be thorough, with themes supported by representative extracts from participants to show both convergence and divergence, ensuring breadth and depth in the analysis.* • Each GET includes contributions from at least five participants, ensuring a diverse contribution that reflects both convergence and divergence of views. • Supportive quotes were reviewed by the research team (an internal and external psychologist), who subjectively confirmed a high level of

Quality criteria	Quality appraisal
	interpretive agreement. Both supervisors also reported good consensus on GET development and evidence.
Sufficient space must be given to the elaboration of each theme.	*Each theme should be given adequate attention, noting it may be more effective to focus on a subset of themes in depth, rather than addressing all themes superficially.* • 2 GETS utilised less space whereas 2 GETS utilised more space, however this was due to quote size and highlighting themes of convergence and divergence. • No subthemes were created, allowing for in-depth analysis of the GETs.
The analysis should be interpretative and not just descriptive.	*The analysis provide commentary on how each extract contributes to the development of the theme, engaging in the double hermeneutic of understanding both the participant and their experience.* • Each quote in the results section is accompanied by interpretative commentary based on the researchers interpretation. • Appendices 8-11 demonstrate comprehensive exploratory noting, including descriptive, conceptual, and linguistic interpretations. • Research team feedback ensured that the commentary extended beyond mere description.
The analysis should be pointing to both convergence and divergence.	*The analysis should highlight both commonalities and differences across participants, demonstrating how a theme is shared while also capturing individual variations.* • A nuanced and in-depth analysis was undertaken for each transcript (Appendix 8), preserving the idiographic nature of participants' experiences of enacting compassionate leadership. • The results explicitly highlight and reflect convergence and individual variation, consistent with IPA's emphasis on how shared phenomena can be uniquely experienced.
The paper needs to be carefully written.	*The paper should be clear and thoughtful, offering a compelling narrative that immerses the reader and conveys a detailed understanding of participant experiences.* • GETs were written in a way such that participant experiences flowed and connected to one another that helps unfold the theme. D • Due to the amount of PETS generated across all participants, it may be possible to create additional GETS, dependent on the researcher interpretations and word count limit. • Feedback from the research team was sought, and compelling quotes where chosen where possible to 'bring to life' the GET.

Nizza et al. (2021) provided more context regarding operationalising elements of Smith's (2011) criteria. Table 13 provides a quality appraisal using Nizza et al's. (2021) criteria.

Table 13

Four markers of IPA excellence (Nizza et al., 2021)

Quality criteria	Quality appraisal
Constructing a compelling, unfolding narrative	*The analysis tells a clear and convincing story, gradually built through insightful interpretation of well-chosen quotes.* • A cumulative narrative was constructed for each GET, with each quote offering a distinct perspective that enriched the unfolding theme, bringing in social graces where possible. • Contextual framing was included to support reader understanding and situate the accounts within participants' lived experiences.
Developing a vigorous experiential and/ or existential account	*The analysis deeply explores the personal and/or existential meaning behind participants' experiences.* • The narrative centred on participants' inner experiences, including thoughts, emotions, and bodily sensations, over mere descriptions. • The analysis highlighted a range of emotional responses and instances of reflexivity, with attention to the influence of social identities and power dynamics.
Close analytic reading of participants' words	*The quotes are carefully examined and interpreted, helping to uncover the underlying meaning of what participants said.* • Appendices 8-10 evidences close analytic engagement through detailed exploratory noting, descriptive, linguistic, and conceptual, as well as the development of experiential statements that reflect a layered interpretation of participant accounts. • The researcher believes a robust process was followed and can be audited.
Attending to convergence and divergence	*Idiographic depth and systematic comparison between participants creates a dynamic interweaving of similarity and individual idiosyncrasy.* • Participant quotes were intentionally sequenced to reflect both convergence, divergence and individual differences. • While subjectivity is inherent to interpretative analysis, this process aimed to balance coherence with the complexity of multiple perspectives.

Adding further rigour, Smith et al. (2022, p.105) state that as a rule of thumb, a GET should be inhabited by at least half the participants for it to be considered plausible, though is not a rigid rule. In this study, atleast five of eight participants contributed strongly to each of the GETs, as table 14 shows.

Table 14

Frequency of GETs across participants

	Group Experiential Themes					
Pseudonym Names	**Self-Compassion**	**Fostering psychological safety**	**A "courageous dance"**	**Deep Empathy: Attunement and Embodiment**	**Misunderstood: "fluffy", "wafty" and unboundaried**	**Navigating uncompassionate systems**
PP1 Liana	X	X	X	X	x*	X
PP2 Jamie	X	X	X		X	X
PP3 Sonia		X	X	X	X	X
PP4 Maria	X	X	X		X	X
PP5 Lola		X	X	X	X	X
PP6 Anjali	X	X		X		X
PP7 Michaela	X	X		x*	X	X
PP8 Amir	X	X	x*	X	X	X
	Note. x* = present but not as prominent as other PPs.					

Overall, this study was rated as a 'Good' IPA paper, having met all key quality indicators in table 12 (Smith, 2011), table 13 (Nizza et al., 2021), table 14 (Smith et al., 2022, p.105) and additionally the CASP (Appendix 12). While no piece of qualitative research is without complexities, to the best of the researcher's ability the analysis remained grounded in IPA principles and was thoughtfully applied within the scope of a doctoral thesis.

4.0 Results

4.1 Chapter Overview

This chapter presents the findings of an IPA of interviews with eight clinical psychologists who strongly identified as compassionate leaders. In total, the IPA process resulted in the development of 6 GETS, summarised in Table 15. The GETs offer both shared and unique aspects of participant experiences. Each GET is illustrated with participant quotes, providing first-order interpretations. This is followed by the researchers' second-order interpretations, shaped by their theoretical and analytical lens, in accordance with IPA's double hermeneutic (Smith et al., 2022). Appendix 1 provides reflective diary extracts of the researcher's lens and an awareness of bias and feelings as part of the analytical process.

Table 15

Group Experiential Themes (GETs)

Group experiential themes
1. Self-Compassion
2. Fostering psychological safety
3. A "courageous dance"
4. Deep empathy: Attunement and embodiment
5. Misunderstood: "fluffy", "wafty", and unboundaried
6. Navigating uncompassionate systems

4.2 GET 1: Self-Compassion

Participants' recognised self-compassion as a necessary part of being a compassionate leader. Self-compassion supported sustainable practice of compassionate leadership, allowed

participants to remain grounded, maintain perspective and involved being "good enough". Six participants acknowledged this.

Liana frames self-compassion as essential to sustaining her emotional and physical capacity for compassionate leadership. Her metaphor of *"fill my own cup"* reflects and embodied awareness of the conscious effort needed to resist emotional depletion:

> *"I have to be able to fill my own cup. In that sense, you know, I'm in a very emotive role as well as well as a system. I need to acknowledge that takes energy, so sometimes being able to say I need to pause…. I do think self-compassion allows more capacity for me to be a compassionate leader. It also there's like a humility towards it as well. So self-compassion for me is also being able to forgive myself and others… but being OK with taking the time to work that out…. You know, it's still hard to be compassionate to yourself".*

Liana uses pauses as an act of self-preservation. Her reference to "*humility*" and "*self-forgiveness*" suggests that self-compassion challenges the notion of relentless self-sacrifice. By allowing herself space to process difficulties, she fosters the internal conditions necessary for a relational presence. However, she also acknowledges the challenge of practising self-compassion:

> *"It's so easy as a professional to constantly minimise your limitations and actually there's something really powerful about being able to acknowledge them and say, 'yeah, I'm at my limit and as a team work out what else can we do?'".*

Liana acknowledges limitations and reframes struggles as opportunities for collective problem-solving. This positions self-compassion as a relational act, reducing the isolation

often tied to leadership. Similarly, Jamie experiences self-compassion as a reflective process that mirrors how she supports others, reinforcing the idea that compassionate leadership starts within oneself. By normalising setbacks and acknowledging both effort and intention, she cultivates resilience:

> *"… self-compassion, isn't it like, practising what we preach to ourselves and kind of saying 'actually, it's OK that it went wrong, you're trying, you're doing your best, you have the best intentions', AND you probably need to repair it AND you can do things about that tomorrow. So I think, yeah, I think that's really fundamental to apply it to yourself as well".*

Her emphasis on reparation without excessive self-criticism suggests that self-compassion is about owning accountability and maintaining perspective, enabling her to be resilient in challenges.

In a different context, Maria draws on self-compassion helping her navigate feeling *"dismissed"* in *"very senior places",* which she hypothesises could be linked to unconscious biases around race and gender:

> *"… how do you remain compassionate within* [Dismissal]*? …. that sort of links into things like racism and, kind of sexism, through no fault of your own… because of what that body looks like, people are having unconscious processes which you can't name. Things are subtly happening… and you can't just be like, 'well, I think that you didn't listen to me because I'm brown'. So then you become somebody who's too forthright, which is acceptable in a man, but you know, labelled kind of negatively in a woman…. in those situations, taking a deep breath and being self-compassionate, then thinking how much of this do I want to do now? How does it feel to step back? How does it*

feel to lean in? You know, what else do I need? Do I need allies? How am I going to manage this? So it's a lot of thought goes into it, but I think self-compassion is important".

For Maria self-compassion is part of her reflective practice, allowing her to pause, assess, and strategically choose her response. Rather than internalising micro-aggressions, *"a deep breath"* helps maintain perspective, protect her well-being, and determine when to seek allies or assert her position.

Anjali acknowledges the unseen labour of compassion self-compassion and regulation, where she negotiates her own limits to remain available to others:

"I think to be a compassionate leader, you have to be regulated, have some self-compassion also…. I think it's very hard to be a compassionate leader when you can't do that to yourself… when actually you're a bit overwhelmed and shut down… and I think I'm a bit shit at self-compassion".

Anjali shared self-compassion involves prioritising tasks and accepting her limitations:

"… there's other stuff that drops down the list in terms of priority… I am only one person with a certain amount of time and so it's accepting in myself that balls will be dropped, that I can only do so much... I think it's being aware of what is good enough".

Her practice of self-compassion is cultivated by her cultural background, experiences of racism and sexism, and, most significantly, motherhood:

> *"…that may be to do with* [culture and family details] *…. I also witnessed lots of racism and oppression, and sexism, and it's made me quite sensitive to those kind of structures for oppression….I also think being a parent has radically changed who I am… what it means for my leadership is that I, I feel like I truly understand the meaning of good enough like on a more visceral level,… I can kind of enact that in my leadership and it means I can hold realistic and understandable expectations of people…. I can only do so much now, with being a parent… so I understand that for the people too."*

Parenthood *"radically changed"* who Anjali was, conveying a powerful identity shift, redefining how she sees herself and how she leads. It also provided a "*visceral*" understanding of what it means to be "*good enough*", which acts as personal permission and a professional ethic which she then applies in leadership to foster realistic expectations of herself and others.

In contrast to Anjali, Michaela felt she had a *"very compassionate"* upbringing, with parents who encouraged self-compassion by being *"kind to yourself and not pushing yourself too hard and not being hard on yourself"*. She acknowledged coming from a *"very privileged white position"* with few adverse experiences, and noted her family's awareness of social graces and difference. She *"would mirror"* her parents compassionate acts, and questioned whether her experiences made it easier to be self-compassionate. Her account suggests this upbringing provided her a secure internal dialogue that permits self-forgiveness, and queries if structural advantage has made compassionate resources more accessible to those without disadvantage. Mirroring her parents points to intergenerational modelling, where early compassionate environments provide a template for enactment in her leadership.

Amir reflects on the tension as "*someone who does go above and beyond*" and connected self-compassion to boundary-setting and managing expectations:

> *"self-compassion links into my own boundaries of maybe there's something I can't do straight away…. I think that's something I'm probably still grappling with, and I think I'm more aware of it now where it's thinking about the needs of the other person and also my own needs ….. it's not all on me to sort everything out, but it can take time….. being compassionate to myself with my time, with what I can do and what I can't do, having boundaries and communicating that as well".*

For Amir, recognising his limits is not a failure but a self- compassionate act. By allowing space for what he cannot do, and letting go of the belief that it is *"all on me to sort everything out*", he repositions leadership as sustainable practice rather than self-sacrificial. Self-compassion is not only emotional care, but also a practical strategy that enables him to meet his own needs, and those of others in a more humane way.

4.3 GET 2: Fostering psychological safety

Participants cultivated trust, transparency, equity, non-judgement and normalising vulnerability as elements that promote psychological safety. Jamie spoke about gently challenging a service lead where communication had broken down:

> *"…how do I do this compassionately without any kind of blame or judgement about this person… my tendency is to look within … to share that I know I'm really confused, I wonder if it's something I've done….. leading that conversation in a way that I hope feels like I'm not putting the blame on them".*

Despite existing tensions, Jamie reflexively considering her role, demonstrating accountability while ensuring the conversation remained constructive and non-judgemental. Her emotional attunement underscores her commitment to creating a safe space, *"mindful"* of further upset:

> *"I was probably abit mindful …that's going to feel more difficult for them and I need to be really skilful in my wording and my affect and my approach to make sure that this feels safe for this person".*

Similarly, Lola emphasised the role of trust and attunement with a colleague over a delicate matter:

> *"… trying to figure out 'What does she need and how?' It's obviously something very sensitive for her. How can I have a conversation… that enables us to think about herself, given she's clearly trying not to feel, keep it professional, I think there's a construct about what professionalism is and isn't. Maybe she's thinking, 'do I trust this person', yeah, I think trust is key, is a really big aspect of it, and I think compassion builds trust".*

Lola and Jamie's reflections reinforce the significance of trust and humanising, stepping in to their colleagues' perspectives as people, before professionals. Trust facilitates sensitive and supportive conversations, providing the foundation for psychological safety.

Michaela described protecting her team from excessive pressure, either helping directly, or providing service-wide advocacy. She narrated:

> *"'Can I do some of the consultations' or 'is there anyone who's got a smaller case load in our team that can help out?' Or do we need to go back to the managers and*

say '… we're going to have a longer waiting list and make them aware of the pressures on the service'".

Michaela actively shields her team from burnout and unsafe practices, recognising silent resilience is unsustainable. She also reflected on the emotional risks when exploring workplace racism:

"…. it was great in the way that people did bring it up [racism]*… where people felt safe…, well, I assume they felt safe, they did say that they felt safe to talk… we had a number of* [reflective spaces]*, so I guess that must be really difficult for people in those circumstances to bring up* [racism] *and to be able to think it's going to be acted on in a way that's not going to make the problems worse and feel they can be open about it….".*

Michaela's reflections suggest that psychological safety enables open dialogue around sensitive issues. She implies compassionate leaders provide belief that meaningful action and repair will follow, which legitimises disclosure.

Conversely, Sonia shares how hostility from a lead consultant eroded her sense of security, making it difficult to extend compassion to others:

"[he is] *really quite scathing …. And he can be quite confrontational about* [service] *and it's not all down to me…. I just don't think he knows what he's talking about. It can be really, really demoralising, and that can make me feel quite defensive, but very, very insecure. And then that doesn't make you feel safe. It's quite hard to feel compassionate as well".*

Sonia's illustrates how breaches in psychological safety, such as undermining her professional security, can block her capacity for compassion. Sonia also described the emotional impact of service complaints:

> *"Objectively, I know this is not personal and I need to take a step back and be very receptive and empathic…. but it can feel very difficult…. when you don't feel safe yourself, it's very hard to then feel compassionate…. when you're feeling vulnerable…".*

Sonia feels that psychological safety is tied to both outward conditions and inner security. When under threat, whether due to internal vulnerability, criticism, or challenging dynamics, her compassionate capacity can reduce.

Liana reflected on power multidisciplinary teams, *"it can be quite an anxiety-provoking"* when *"loud voices get heard more often".* She narrated dialogue between a colleague asking *"are we doing okay?"*, with their perception of senior staff replying *"let me judge what you're doing, are you doing enough?"*. She reflected this culture leaves staff feeling *"vulnerable"* and her role:

> *"… it isn't to look at people as a tick list of what have you done, a lot of it about 'how are you doing with this work? How are you feeling? What are you thinking and noticing and bringing up and being curious', also with my own emotions that get brought up as well, and I guess it's part of that is modelling that to my team".*

Liana resists traditional performance-driven hierarchies where input is measured against *"tick list"* metrics, and instead values emotional presence. She is deliberately

countercultural, challenging performative dynamics by *"modelling"* vulnerability. Liana hopes to cultivate a space without fear of judgement; a hallmark of psychologically safe leadership.

Liana later connects her own sense of safety to absence of representation in leadership positions among those who share her background:

> *"… where's my representation? … that comes with safety…. there's not many* [Like me]*… It'd be lovely to be able to find common ground…. who has had similar experiences to me, for example, in in, in another identity would give another layer of support…. I have very and clear kind of experiences and emotions and feelings that come up and some are related to race and ethnicity, but where would I go for that in terms of coping and managing?"*

Without peers who shared Liana's lived experience, leadership feels isolating. Her reflections illustrate that psychological safety is entwined with structural inclusivity. Amir also shared feeling *"very lonely"* in his context from a global majority identity, but conversely uses it *"as fuel"* and *"like a compass to guide* [him]*".* He describes getting used to it as *"…what helps* [him] *is seeing* [the situation] *slowly changing".* Amir transforms his feelings of isolation into a motivation for inclusive action, feeling safer due to self-belief and systemic changes, albeit still feeling lonely.

Maria exemplifies psychological safety as both a relational and structural act of compassionate leaders. She adjusts expectations based on her team's emotional and workload demands by *"calibrating the task to the temperature of the group"* where this facilitated *"a safe space, a space for their* [staff] *whole selves to be seen"*. She described offering solutions sensitively:

"I would say [softer tone] *'well, actually you're probably going to be at the hospital quite a lot, so do you want to do xyz or is there someone else? Or I could pick this bit up?'".*

Maria's aims to further alleviate stress by consciously slowing down processes to deal with the *"blame culture*", explicitly *"building psychological safety*" through reflection rather than reaction:

"… being really open, and building psychological safety…. it was about slowing everybody down, because everything else was so threat,… so much in drive that it became like the red circle and blue circle were really big [compared to a small green circle[8]]….*people are very worried about getting things wrong…the fear about blame culture…'OK, let's just take a moment here, let's just think about this'"*.

Maria articulated her view through Gilbert's (2009) three-system model, where she sought to develop a soothing space where mistakes can be discussed openly without fear, encouraging a learning culture, rather than retribution. Maria also resists hierarchies by facilitating transparency and power sharing:

"[Narrating] '*This hopefully is a space where you can share things that are difficult and that sometimes it may be this relationship…. and I'm hoping that you would come to me first…, I do appreciate that that is also difficult. So you have permission to have that conversation with somebody else'…. I'm not saying that would be particularly nice for me to experience, but what I hope I'm doing is saying 'I'm not*

[8] Maria references the three-systems model (Gilbert, 2009). The *red circle* represents the threat system (fear and anxiety), the *blue circle* represents the drive system (motivation and goal-directed behaviour), and the *green circle* represents the soothing system (calm and safety). A balance between these systems is crucial for emotional wellbeing, with an overactive red or blue circle potentially leading to stress and burnout, while an activated green circle facilitates emotional wellbeing.

above you, I'm not going to enact my power that you can't go and talk to anybody else about it'".

Despite feeling uncomfortable, Maria willingly relinquishes power, positioning herself as an equitable leader, supporting psychologically safe environments where vulnerability can be openly shared. Similarly, Anjali describes psychological safety as necessary in enabling constructive challenge within her team:

"… like challenging one another takes a lot of courage and vulnerability to potentially be wrong…. It's quite risky business…. I'm in a position of power… I really want to model that I can kind of tolerate those challenges. I think it's about psychological and emotional safety…. feeling grounded in yourself… confident in who you are in order to be challenged enough to not shake your whole identity".

Anjali acknowledges the "*courage and vulnerability"* needed for respectful challenge without fear of repercussions, and this requires leaders who are secure in themselves, providing stability for others to speak up.

Anjali also integrates a deeper understanding of the social and cultural dynamics impacting her staff's emotional experiences. She reflects on supervising two women from different global majority backgrounds, each experiencing challenges when "*… meeting with a family of a different race and culture"*. She recognises that race, power, and identity dynamics require emotional support and protection:

"[Narrating] *'what does that mean? Or how does that feel for you? How do you feel that you're being perceived?' Because a lot of our social care staff are from ethnic minorities, and doing this work, and they're holding a position of power with the*

family. That can, can be really complex and delicate and stuff can be played out.

[Second example] *we thought about and acknowledged what that's like for her, particularly in the recent context of anti-immigration and protests…. how who they are, how that plays out, and what protections do they need, if any".*

Anjali facilitates psychological safety by recognising how sociopolitical and cultural intersectionality shape human experience, moving generic supervision to cultural safety. She gives voice to race, power, and context, which reinforce a commitment to inclusive and anti-racist practice, where silence may be seen as complicit.

Amir echoed this. Regarding staff *"from racially minoritised backgrounds who have had harmful experiences*", he prioritises empathy, and is aware of the intertwined personal and professional challenges colleagues face:

"…work already is difficult… emotionally as well…. [staff] *have their own mental health difficulties or personal things going on… people don't need anything added to their plate…. I think about how difficult it is for someone to share something with me that has happened….. 'OK, what can I do? What can we do?'. Giving them space… I always try and make time somewhere else …. I can sometimes feel a bit stuck and I don't know what to do… it's just being transparent…. Like 'I don't know the answer right now, but let me just try and find out and I'll I'll get back to you and I'll let you know'….. just opening up that conversation within supervision, it helps".*

Amir acknowledges his own limitations and expresses a willingness to find solutions and model transparency. He intentionally holds space for discomfort without rushing to solutions. This fosters trust and mutual respect, where staff feel seen and empowered to share their challenges.

4.4 GET 3: A "courageous dance"

Participants explained that compassionate leadership is not kind and passive, but instead a *"dance"* that requires courage and bravery to act with intention, self-awareness, and an ability to navigate interpersonal dynamics despite there being moments of vulnerability. Five participants spoke to this theme, with Jamie in particular feeling this was the heart of compassionate leadership. Jamie felt compassionate leadership was:

> *"… like curious understanding phase, but also the courage and the strength to do things about it… it is actually just a really courageous dance. It involves kind of risk taking and really going there with people to bring about change and to make things better, rather than just sitting at the problem and empathising with understanding. I think it has to have those two streams to be effective".*

Jamie also expressed her duty of care to an underperforming staff member, weighing up *"what she needed and what the team needed going forward, and whether she was able to fulfil that duty still or not*" with needing courage to be honest:

> *"And I guess that's the like the courageous daring part of like, actually, I can be as kind as I can to this person, but also we need to prevent suffering and the children and* [*school*] *need a clinician that's able to fill their role".*

Jamie was navigating both her own and the staff member's vulnerability, while upholding team wellbeing and effectiveness. Jamie explained how moving to action brought out feelings of panic to what she described as a "*fine dance*" between "*allowing her* [staff member] *to be vulnerable*" and "*have the more difficult conversation*":

> *"I probably felt a bit panicked at the beginning, a kind of God, we can sit with this for as long as we need, but in essence it's my responsibility to work out what we do about this and how am I going to do both?!"*

Panic reflects the tension between wanting to provide a safe space for staff to express their vulnerability while also taking hard, but necessary steps for the best interest of all stakeholders impacted. In another example, Jamie reflected on the challenges of asserting herself against a more experienced male colleague which required bravery:

> *"I do feel quite conscious… an older male professional in his 60s and I'm coming in, in my 30s, saying things need to change or this isn't good enough, and what can we do about it? That feels really difficult. So I imagined myself in the minds of others, and how they might be viewing me, and I think sometimes that can get in the way a little bit, and I probably dance or, like, tiptoe back into sitting with again… I don't know if part of that is experience too, in time with enough practice, it will become more effortless. But yeah, it's definitely a conscious process or like a leap of faith like, oh, I'm going to do it! Yeah, bravery, I guess".*

Jamie's awareness of hierarchical and gendered dynamics made it difficult to assert her position without hesitation. Her metaphors of *"dancing"* and *"tiptoeing"* convey a cautious navigation of her discomfort and self-doubt, however, the act of moving from contemplation to speaking up feeling like *"a leap of faith"* highlights the courage needed when potentially being viewed as naive while asserting her views, which she hopes becomes easier with experience.

Liana also spoke to needing to be courageous when recognising the discomfort within herself and her team, when pausing discussions that disrupt team momentum, though felt thought decision-making was essential:

> *"…ohh gosh, I could be putting a spanner in the cogs when people are wanting to move on to the next thing, and they've run with an idea for 10 minutes, it can take me courage to say 'hey hold that, stop, pause, let's think about this'…. I narrate it, being explicit with my team, the rationale… 'I'm trying to slow down thinking because, I'm just curious about this because' so there is some of that and being able to model that for my team…. in terms of the consciousness about it, is overcoming that anxiety to be able to say that and model that to my team, I have to admit, it does take a bit of courage sometimes as well".*

Liana acknowledged the internal anxiety yet framed this as a courageous act, and intentionally modelling this behaviour. Her deliberate narration of her thought process suggests that bravery in leadership is not just about making difficult interventions, but also being transparent in the discomfort of doing so.

Sonia also described how enacting compassionate leadership demands personal vulnerability, especially when supporting Jewish students and trainees after the 7th October 2023 Hamas attack on Israel:

> *"My* [primary] *identity is being Jewish, and that's really important to me. Within the last year, it's been particularly challenging… Jewish students and trainees have not felt particularly safe psychologically and felt very attacked, and I've facilitated supportive structures for them… they're not something that's easy to talk about.…* [I] *write an e-mail to the teams about an upcoming Jewish holiday … I'll take in some*

food associated and I'll leave it in the kitchen and I'll write a note, and it makes you feel slightly vulnerable and exposed…. usually you get a few people that will write an e-mail back and say, oh, thank you so much, that's really interesting, and all these kinds of things…so it's also quite exposing. It doesn't come easily to me to stick my neck out and to put myself forward in that way".

For Sonia, compassionate leadership extended beyond comfort, to take visible and uncomfortable action. The metaphor of *"stick my neck out"* speaks to the personal vulnerability of leadership when addressing sensitive issues, particularly as it touched her identity. Despite feeling exposed, she pushed through:

"A lot of times as a leader in a leadership role, I feel very uncomfortable and I feel vulnerable, although I have to just, I have to sit with it. But I also know that, you know, it's like exposure therapy. The more you do it, the easier you get".

Sonia's comparison to exposure therapy suggests that repeatedly practising acts of courage gradually makes discomfort more bearable. Similarly for Maria, she felt it was necessary and important to hear uncomfortable feedback rather than silence others to uphold "*agency*" and openness:

"…if it makes me uncomfortable for you to go and talk to somebody else, if that means you can't talk, then that's not OK, and that's not in my value system, that I silence you in some way. So yes, it might be uncomfortable, but maybe that's something I need to hear…. Maybe there'll be unfair things coming my way, but that's not a reason to not even give people agency. I think that's the power of leadership… you have the ability to take away people's agency and you have to be really mindful… you have to hold power carefully".

Maria demonstrates the courage to accept discomfort and hold power sensitively, resisting the urge to self-protect by silencing others, and instead choose to engage with difficult feedback and tolerate discomfort. Her stance means compassionate leadership prioritises ethical responsibility over personal ease.

In a different way, Lola described courage in leading authentically as a black woman, acknowledging it would have been easier *"toeing the line"* or conforming, as she perceives some global majority politicians have done:

> *"It would have been easy for me to, to be a black leader that toed the line and I think that would have been easier… like Rishi Sunak and Suella and Kemi* [non-white politicians], *like, like there's a faster way or it's a risk, it's a gamble, isn't it? by saying I'm going to be just like these people, be a leader that's at the top of the tree. But I think the harder, longer slog road is to do it this way, sticking to my values".*

Lola's use of "*risk*" and "*gamble*" highlights the uncertainty and potential consequences of intentionally asserting her identity by choosing the "*harder, longer slog road*" rather than conforming. Lola then reflected on how she has become braver over time:

> *"I've changed as a person and might be more like more owning it. More, more confident, more able to speak up…..I think my generation you, there was a kind of assimilation, you just stay quiet. I used to do my thing… I wouldn't shout about it. Whereas now maybe as a leader, I'll be much more able to say 'No, I'm going to do it like this because my identity, my life experiences mean that this is how I do it'… I'm much more giving my actual self rather than mold my answers to be what I think they want to hear. So now I'm like, but this is who I am, and if they want it, they'll take it."*

Lola's journey from quiet assimilation to authentic and intentional self-expression highlight how compassionate leadership requires stepping into discomfort and taking risks, despite the uncertainty of how it will be received, and contrary to the nice and passive perception of compassionate leadership.

4.5 GET 4: Deep empathy: Attunement and Embodiment

Five participants spoke to a deep connection and felt responses to their staff challenges, beyond a surface-level understanding. For Sonia, leadership challenges felt emotionally complex, especially supporting a staff member who continued to struggle despite clear support systems. She described experiencing *"exasperation", "irritation",* and *"self-doubt"*:

> *" Both exasperation and wondering whether I was being a bit naive because* [details of supportive plan] *and she still hadn't done any of it. So then I'd be feeling anxious, but also irritated and exasperated… because it wasn't safe….. So then we'd have this* [formal performance] *meeting, which I felt, vicariously, the shame… It was very humiliating for her, it was shameful for her to have to sit in a meeting and to be told off like a child…. and not be able to trust … I just felt for her, because I really liked her because she's really hard working. But I also felt I did feel quite cross with her at times as well, because it was like she would self-sabotage…but then doing these other brilliant things".*

Her emotions oscillate and conflict between anxiety, "*being cross with her*", liking her, losing trust, and remaining hopeful. Sonia does not simply acknowledge her staff member's humiliation and shame, she *"vicariously"* experiences it, positioning compassionate

leadership as an affective practice. Despite her frustration, Sonia remained emotionally attuned and empathetic, as she sensed "*self-sabotage*" in the behaviours she witnessed.

Amir described enacting compassionate leadership as an embodied event, noting the physical sensation of warmth, which may symbolise a sense of connection and presence:

> *"… it's more of like a feeling of the body. I think quite warm, like I feel quite warm. Say I'm speaking to someone and I'm being patient, listening to them… helping them or supporting them…. not needing to rush to any sort of final endpoint and just take the time…. more a feeling like quite warm and just feeling patient 'cause I think in the past I've sometimes been very quick, very quick to do things. And also just I think sharing that responsibility with the other person by generating solutions together. So not feeling like it's all on me…".*

Amir's shift from a reactive stance to reflective and embodied practice allows space for a more thoughtful, co-created process. The implicit reference "*feeling like it's all on me*" may be the heaviness felt internally when he was solely accountable for outcomes.

Liana shared a different example, relating to how feeling "*powerless*" and "*inferior*" manifests as anxiety when needing to assert herself in hierarchical spaces, and stated this was not "*encouraged as much*" in her upbringing:

> *"My anxiety can also come from I'm working in a system and area that's very white middle class…especially very recently given the race riots, I am very aware of the biases within the system… I have also had experiences of racism…. I also hold the same feeling of threats and safety….* [Panic gesture] *I hold another layer of 'now a*

white middle class man is angry because of my actions, and I'm from a working-class family and an East Asian woman in a system that's all white and hierarchical'…."

Liana's demonstrates self-awareness of how her socioeconomic background, ethnicity, and gender intersected with systemic hierarchies, contributing to an internal sense of threat. Having also experienced racism, this may also be held somatically. The "*race riots*" contextualises how external events heightened her sensitivity to systemic biases. She further reflected on inner states:

"…the feelings are quite explicit to start off with, and it does take some in the moment reflection to go are these feelings so big, because this is actually what's happening?....Why am I feeling these things? I'm gonna validate how I'm feeling in the moment, when there's potentially is a really anxious white man infront of me or just an anxious manager in general before all the other kind of identities?....Why are these big feelings so big for me?.... it could also be because I'm a woman?... because he's white?... because on the hierarchy he's higher than me?...Oh, what are these feelings of powerlessness? Where are they coming from? Is it because he's actually made me feel that way? Or is it because of previous experiences?".

Liana's reflective process alternates between acknowledging her immediate bodily sensations of anxiety and threat, to questioning whether these responses are rooted in the present dynamic or shaped by accumulated past experiences. Her emotions feel *"big"* such that they catch her attention and she seeks to locate their origins. She then explicitly connects her emotional response to a trauma response, noticing her instinctive bodily reaction before a conscious intellectualisation or contextualisation occurs:

"It's being instinctual… allowing myself to feel that not to push it down, cause it's quite easy to push those feelings down…. It's almost like a trauma response… my body's feeling the trauma response is instant".

This suggests a deeply ingrained somatic memory, where her body pre-emptively registers threat in response to power imbalances. Her attempt to "*push those feelings down*" versus "*being instinctual*" reflects a tension between emotional suppression and embodied processing.

However, Anjali, Lola and Sonia provide examples focusing on connecting and containing others' emotions. Lola reflected on the embodied and transferential experience when she illustrated absorbing the emotional weight of her staff member's disclosure. Lola felt the factual manner in which her staff member shared the information, left her to carry the unexpressed emotion:

"…I burst into tears…. there'd been no emotion that she'd given. Like she'd given it all to me, and I felt it all….. I then shared it with her in the next supervision …. she was careful…. she didn't really want to go into it much, but I was able to use what had happened to me to just guide my questioning, like to hypothesise, 'I can't imagine what it must be like, especially [personal]*…. its okay to take a day off and that would be fine and just allow yourself to feel what's happening' because my sense was she put the feelings of it in a box over there".*

"*Bursting into tears*" encapsulates how Lola somatically held her staff member's emotions, before consciously processing them as a channel for both their unspoken distress. This was used to gently invite reflection, sensing her staff member's reluctance to engage

deeply with her feelings *"in a box"*, but to also create permission for emotional expression. Lola explained why she shared her emotional reaction:

> *"I guess to not shame her or have her feel inadequate in any way for having to go through* [procedure]*. I think that's a common feeling that women feel inadequate…, but also I didn't want her to feel like showing more emotion was wrong".*

Lola was attuned to what was unspoken, with an awareness of potential shame and gendered expectations to fostering a safe space where emotional expression is neither forced nor suppressed.

Anjali also spoke to a supervisory relationship, stating they feel *"close and personal*" and that "*it is about supporting with the delivery of clinical work but it is also about holding that colleague, and often kind of containment and support*". She shared her thought process of attuning:

> *"…where is this person at the moment? like how regulated are they? Are they getting their personal needs met outside of work?... Is any part of this work touching on their own kind of sensitive parts of their own history? Oh, with all of my supervisees we exchange and share a genogram, and I ask about social graces and characteristics and things like that….. what brought them to the work, so that's what I'm thinking about… what does this person need from me right now? Do they need guidance? Direction to be held? And what are they really asking? Because often the thing that they're asking isn't what they're really asking".*

Anjali considers multiple layers of wellbeing and appears to seek signs of potential distress before it surfaces, suggesting attuning is an important part of co-regulating her staff.

Furthermore, sharing genograms reflects a deeply relational style, allowing her to share aspects of herself with her supervisees and see them as whole individuals, not just professionals. Similarly to Lola, Anjali was attuned to the unspoken, suggesting "*the thing that they're asking isn't what they're really asking*".

Anjali, Sonia, and Lola each described a deep sense of care, advocacy, and emotional investment in colleagues, reflecting connection to their personal and emotional realities. Anjali articulated a strong desire to protect and enable her staff:

> *"…I really want to kind of protect them and look after them and enable them to grow, develop and, do some of the advocacy that I spoke about in terms of ensuring that they get their needs met in doing their clinical work, like do they have the resources they need?".*

For Anjali, compassionate leadership extends beyond a professional obligation to a relational process rooted in ensuring her staff also have emotional resources needed to thrive. Lola echoed this nurturing perspective, explicitly stating *"…motherhood, and management, is a bit like parenting, actually, abit thankless, thankless",* but was deeply fulfilling:

> *"You give the world, but the minute you get it wrong, you're told about it. You can't really ever get it right for everybody, but you're always trying your best…. we recruited an administrator… and she went off to train as a therapist, and she sent me a photo of her in her graduation gown, and again, I burst into tears. I was like, 'Oh my God, I'm blubbing on the train… I'm so proud of you!'….. and similarly, someone we took on as a volunteer… just qualified as a clinical psychologist, and again, it's just like my psychology daughters!".*

Her emotional investment in her staff was powerfully illustrated when she recalled moments of pride in their professional achievements. The metaphor of *"psychology daughters"* reveals a maternal connection to her staff's journeys, with "*blubbing on the train*" further reinforcing how raw emotions are expressed rather than merely acknowledged. Sonia similarly framed her leadership experience through her maternal lens:

> *"… I've got some of these band fives, for example, are the same age as my own children, So I think sometimes I feel this kind of slightly maternal sense towards them….".*

For Sonia, this emotional attunement was heightened by her personal experiences, allowing her to deeply feel the struggles her staff faced, having also walked a similar path, stating "*I remember how demoralising it was, I feel angry on their behalf as well. I mean, it's just not fair*". Her vicarious anger for her staff demonstrate an embodied response to perceived injustices within the system. Overall enacting compassionate leadership involves being emotionally attuned while also feeling an embodied response whether it is a positive or challenging experience.

4.6 GET 5: Misunderstood: "Fluffy", "Wafty", and unboundaried

Compassionate leadership can be misunderstood as weakness, or as an open-ended form of goodwill, with participants suggesting there are boundaries that compassion operates within. Seven participants spoke to this theme.

Jamie, Lola, Liana, and Maria felt undermined when enacting compassionate leadership, reflecting on the intersectionality of their gender, and age or ethnicity. Jamie stated:

"… the age and experience thing too, it probably a feels like a barrier at times in terms of, I guess people buying into what I'm doing".

With Lola adding:

"… for sure as a woman and as a black person, being compassionate is seen as being too nice or being a bit naïve, and isn't valued".

Liana agreed sharing she is perceived as "*soft*":

"… [sarcastically] *'oohh women being very compassionate at work, all being so kind', so thinking about gender, especially in social care, it can be seen as being soft".*

Maria, similarly added that women are expected to be polite:

"And I think there's also something about external expectations that women are expected to be nice. So, when they're not 'nice', when they don't always just nurture, there's a double whammy [gender and ethnicity] *for women from the from the global majority".*

Maria stated she had been made to "*feel invisible and dismissed*", which encapsulates a broader sentiment shared by Liana, Lola and Jamie; compassionate leadership is undermined when enacted by those who do not fit traditional leadership archetypes such as younger women, or women from the global majority. Jamie also identifies *how "older systems"* reflect a cultural attachment to hierarchy and control, perceiving compassionate leadership as lacking credibility:

"…trusting that this style of leadership is effective and not like a weakness. I think that's sometimes how it's viewed, particularly in kind of older systems that are maybe used to more rigid structures".

Jamie also stated "*sometimes compassion is seen as like floaty and wafty and being really nice to someone and letting them off the hook*" and *"…old beliefs I held around stereotypes of wafty and fluffy*". This suggests that traditional systems may perceive compassionate leadership as lacking structure or authority rather than being recognised as an intentional and effective leadership approach, with herself coming to understand it is a structured and effective method that challenges inaccurate stereotypes.

Amir addressed the misconception of being excessively permissive when he spoke about supporting a colleague who increasingly wanted to work remotely, but Amir had to "*try and accommodate everyone's needs*", stating:

> *"You want to support someone and be compassionate, but not kind of give the message that someone is free to do whatever they want and not remembering that they are an employee".*

Amir emphasised the use of boundaries, explaining:

> *"Yes, compassion important, but not to where people can just feel like they can treat us how they want to, or do what they want to. And I think that's a bit of a balance between being compassionate and having boundaries".*

For Amir, compassionate leadership is a balancing act ensuring fairness and accountability, while avoiding exploitation. Lola, like Amir and Jamie, challenged the notion that compassionate leadership equates to excessive permissiveness, and highlights that when compassion is unbounded, leaders risk losing strategic clarity:

> *"…they're almost too compassionate. Like, they don't get stuff done, or they lose their managerial thinking by getting sucked into the stories… and she loses seeing the*

bigger picture. It's frustrating actually. You're supposed to be managing those relationships or strategising that, and so if they're not doing it, I have to do it all. There's a balance. How do you still have compassion and step back and operate at a different level, which means you're maybe less close to the stories…".

Lola's reflections point to a balance between empathy and action. She recognised the need for leaders to maintain a degree of distance to preserve their decision-making ability, as this led to her feeling burdened, impacting overall organisational effectiveness.

Sonia illustrates how compassionate leadership can be misunderstood when enacted without clear boundaries, shared norms, or accountability. She reveals the emotional strain and moral complexity that can arise when wellbeing-related policies, are perceived as inequitable within already pressured systems:

"… people who've just sort of gone off sick with [confidential]*… it's not helping them and it's not helping the service…. the rest of us get left picking up pieces… and work extra hard to do all the stuff they're not doing…. it is hard to feel compassion in those times….I think people are taking advantage and ultimately it's not to anyone's advantage".*

Her frustration appears not with the principle of compassion, but at how it is applied. Compassion without boundaries or accountability risks enabling patterns that feel inequitable, unsustainable and may be experienced as permissiveness. This tension deepens as she observes behaviours that, in her view, conflict with the spirit of self-care:

"…lots of people were angry that got 6 months full pay… [visibly tense] *I feel horrible to say it but just think it's taking advantage … maybe I'm judging and I don't know*

> *the exact situation, but I was hearing and seeing stuff on social media* [manicures, pedicures, holidays] *… to me seemed like self-indulgence, not self-care".*

Sonia does not reject compassion, and points to a systemic misunderstanding, that without structure, transparency, and mutual accountability, compassionate leadership could feel unfair and misaligned with team values, which may inadvertently create division rather than cohesion, and even be resented. Sonia also reflected on supporting the performance of a colleague, attempting to balance firmness with support:

> *"I want to support her, but I also know that I need to be quite firm about this and I want her to find me supportive and it felt important to me that she didn't experience me as being aversive…. One of the very senior managers was quite punitive and he thought that I was being far too soft…. 'I'm just a bit of a soft touch, I'm being too nice and giving it too much of the benefit of the doubt'….. and then one of my colleagues was saying, 'you know, you're tolerating far too much from her'".*

Sonia's experience was complicated by differing perspectives of colleagues. While she intentionally sought to maintain a structured and non- *"aversive"* approach, others viewed her leadership as too lenient; this portrays how compassionate leadership can be misunderstood.

Michaela echoed Amir's and Sonia's concerns about the risks of being "*too compassionate"* in relation to agile working and performance management. She reflected on the tension between individual circumstance and collective accountability for team cohesion. When discussing staff cancelling last minute for in-person team events, Michaela grappled with whether she should adopt a firmer stance:

"… they're all very valid reasons and you know, you're compassionate self is like 'oh right, yes if that was going on for me, I'd find it tricky to come', but should I be more assertive and say, 'look, this is a team event that should be prioritised and it kind of lets the rest of the people down'".

And, in relation to performance:

"Is the person not performing because, to take advantage of a situation? rather than actually having real issues going on that means they can't perform in a way that's needed for the service? That's when I might think, am I being too compassionate in this situation?"

Michaela questions whether responding with leniency is a compassionate act, or, if it might inadvertently allow for continuation of the situation by failing to address the underlying issues. She illustrates the complex negotiation between maintaining compassion and upholding expectations that support the broader needs of the team and service.

4.7 GET 6: Navigating uncompassionate systems

All eight participants spoke to how their system impacted their enactment of compassionate leadership. Although compassion leadership through role modelling was seen to *"ripple"* through the H&SC system, the overall sentiment is that compassion feels structurally constrained.

Michaela appeared to be the only participant who spoke to the consistent application of compassionate leadership. She shared that reflective spaces discussing workplace racism were "*run by the overall psychology lead, so for someone to give time to help us support us as a team felt very supportive*". Here, visible and active senior leaders

facilitated open dialogue, enhanced trust, and reassured staff that raising concerns within a trauma informed service seeks to avoid re-traumatisation by ensuring staff and service users feel safe, respected and empowered. Michaela stated her staff *"want to develop therapeutic, trusting relationships with other humans"* and reflected:

> *"… having a team that are trained to be empathic* [lists person centred skills]*.... their understanding others life events…. they're quite a cohesive team …. they trust each other that they can say 'I was really pissed off when this happened,' rather than keeping it to themselves…. So if they're compassionate and empathic when it's at one person's turn, then, when it's their turn, you know, they will have the same response…. other people will jump in with 'oh, I'm quite low on caseload at the moment, or I'm finishing with a lot of people, I can help you with this'. So that's kind of what happens in the team.*

She describes her local system being engrained with empathy, cohesion, and trust, which foster compassion. She further describes compassion reciprocity within the system, whereby compassionate acts for others are later returned with colleagues volunteering to pick up workload from others. This links to the idea of compassion trickling down and role modelled through the system, as Jamies, Liana, Lola and Amir also referenced this. Jamie stated:

> *"… modelling is very important…. you see it being done, it then empowers other people in the system to do the same…. when you experience it yourself… you're like, 'oh, yeah, you did that with me just then in that meeting and I feel really valued, seen, heard, and I wasn't offended…. when you experience that you know how to do it, or you see the benefit of it".*

Liana added, that although encouraging staff to be open about their challenges meant they took short term sick leave, this mitigated long term sickness:

> *"… there's definitely been a change in being able to model compassionate leadership more often… my* [team] *are definitely more open about their feelings and being able to say when it's hard…..it's like a positive spiral, spiraling up. Compassionate leadership meant validating people's health and saying its OK, your role will still be here when you get back."*

Lola agreed with this sentiment:

> *"… as leaders* [if we] *don't treat the people you're leading with respect or compassion, you can't expect them to do the same…. If we treat people badly, it's gonna come out, either they are going to be off sick or they're going to be stressed …. from a business point of view, if you're thinking about getting the best outcomes…treat your staff well!".*

Amir stated that when he received compassion, he wanted to pay it forward:

> *"I've appreciated when supervisors have been compassionate towards me, and now I try and do that with people that I'm supervising with, with the hope maybe when they're in leadership positions that they can remember, positive experiences and maybe take that forward as well".*

Across participants, compassionate leadership gained systemic momentum when role modelled. This drives a reciprocal, *"upward spiral"* in compassionate culture. Visible and felt compassion, legitimises its use, and implies compassionate leadership is relationally

contagious: it is sustained not through policy, but through embodied practice that signals safety, respect, and humanity.

However, most participants spoke to the inflexibility and incongruency of healthcare systems hindering compassionate leadership. Sonia felt the system *"stuffed"* her pre-qualified staff career progression plans, and her power was limited in resolving this:

> *"… after doing the job for 2,3,4 years they can't progress on…. they don't have a core profession, and they're completely stuck, there's nowhere for them to progress to and it's really frustrating …. they're kind of left feeling unvalued and demoralised, and they want to leave, …* [it's] *a reflection of the service structure".*

Despite her frustrations trying to help in various ways, she had no choice but to accept the situation:

> *"… this is just an impasse I need to accept, I can't really do anything else other than what I've done and just keep doing it…. for these particular staff there isn't really anything else I can do for them….".*

Her tone was one of sadness, perhaps vicariously carrying the emotions of her staff.

Maria shared her view on how *"compassion focused leadership training"* risks being performative when there are system pressures:

> *"…it can be tokenistic … our system is about being kind and civil, but when it comes down to it, you don't really know what's, what's being said in a referrals meeting, where everybody is completely overwhelmed…. people are really worried, like 'I'm already scared about the size of my caseload, … I don't quite remember what was happening with them and now to take somebody else?'….. It could feel really*

disingenuous to be [sarcastically] *'so I think we need to talk to each other compassionately'. You know, they'll be like 'what?'. When actually, I don't really need to do that, I need you to actually get more people in".*

Maria's reflects that compassionate leadership could be a tokenistic gesture for kindness and civility it if neglects deeper structural implications. Lola also made the same point regarding organisational values that seem to be in words only.

Participants reflected on the emotional and practical strain of working within systems they experienced as inflexible, fast-paced, and having misaligned goals. Amir described feeling caught between conflicting demands of the service, patients, and staff wellbeing, and grappled with how to lead compassionately in such constrained conditions:

"*…the needs of the team aren't matching up with what the needs are for the individual or the needs of the service…when it just doesn't match up what do you do? Do you prioritise what the service needs?... or do you prioritise your staff wellbeing?... I would bring compassion in these situations by acknowledging... we are in a really difficult situation and a responsibility in coming together…".*

Here, compassion becomes both an ethical guide and a practical tool for navigating systemic dissonance, enabling Amir to hold relational space even when structural solutions are lacking.

Lola identified a deeper ideological misalignment, describing the system as fundamentally shaped by *"traditional principles and values"* that resist the mindful, reflective pace compassion leadership requires:

"...you're always going against the tide, which again is exhausting, it's tiring, but it's also enriching and enlivening.... you can't have [mindfulness] *without* [compassion}*.... Being aware…noticing, paying attention…services aren't very good at this…I feel I can be more compassionate if I'm more mindful. But I don't get time… the way we configure time in services I think is counterproductive, and makes it really hard to be compassionate".*

Her language conveys a paradox: the scarcity of compassion within the system enlivens her desire to lead with it even as structural constraints around time erode the space needed for mindfulness and emotional presence.

This tension was echoed by Liana, who described a culture of *"firefighting"* where *"there's always an added pressure of this needs to be decided by tomorrow"* which caused compromise:

"… it's a lot of knee jerk reactions, intervention after intervention…. it's quite a fast system… and what that means is people [don't get] *heard or things are missed.… careful listening and thinking time... can fall by the wayside".*

For Liana, there is tension between the need for quick decision-making and the value of compassionate listening. Pressure to make quick decisions can hinder the ability to listen and reflect. Sonia also cited *"red tape",* being a *"firefighter"* and time pressure , limiting her ability to be compassionate:

"……when somebody comes and says 'Sonia, can I just ask you something?' the times when I think, 'Oh, go away, leave me alone', that's where I'm thinking like I've lost my

compassion…".

System pressures cause Sonia to become reactionary and defensive.

Jamie offered a comparative perspective, reflecting on leading from the *"outer sphere"* helping her preserve compassion. She questioned if being at a distance, taking a *"helicopter view*" afforded her the ability to "*slow things down*", but felt *"chaos"* and *"blindsided"* in frontline work in trauma services:

"...compassion can be a little bit harder... you're just absorbing it all…. really hard to step out of that".

Her reflection questions whether systems genuinely create space for compassion to be sustained, or whether they remove it in environments that offer no respite from emotional intensity.

Anjali stated *"it's quite hard sometimes to kind of hold that compassion for other services in the system"*, when they felt inaccessible making it hard operate in:

"… to hold in mind other positions as well, like the services we refer to, and understanding why they do things the way they do. Although, I think sometimes services are designed on purpose with intention for people to not access it? So, I think my service is just as inaccessible in some ways, and I think I think that can be challenging as, as well, to kind of understand the positions of other services, other managers".

Anjali's candid insight reveals the emotional toll of navigating the logistical demands of a system she experiences as lacking compassion, where she perceives exclusionary practices embed structural harm, even as she strives to remain empathically attuned.

Liana reflects a contradiction in systems; with empathy expected for clients, but self-empathy feeling institutionally discouraged:

> *"If you're able to create* [an] *environment where it feels safe to be able to share emotions, and share that it's really tough sometimes… staff have obviously very clearly buried all their emotions because it's not something that seems important in their role, 'I can be empathic with the family, I can be empathic with the system, but not being empathic with ourselves'".*

The expectation to *"bury"* emotions reflect an institutionalised narrative that self-compassion could be less legitimate. Liana's hopes her service can challenge the norm of self-expression, reflecting a desire to rehumanise the emotional lives of staff and prioritise wellbeing.

Maria concluded the interview with a firm rejection of individualised models of compassionate leadership feeling it should be a collective responsibility:

> *"It's a systems thing and I think it's not about one-off experiences, and it puts the responsibility into the individual, and I think we can't have an approach that isn't supported by a system".*

Her dissonance raises a clear concern that without compassionate systems, compassionate leadership becomes unsustainable, placing undue burden on individuals. For Maria, genuine compassionate leadership cannot be meaningfully enacted unless it is embedded and upheld at an organisational level.

5.0 Discussion

5.1 Chapter Overview

This chapter will discuss the GETs generated in relation to the research aim and question. The findings will be presented in the context of existing literature relating to the GETs, including any theories, models and approaches relevant to each GET and compassionate leadership. Implications will also be embedded within the discussion of findings. Recommendations will then be made, followed by strengths and limitations, directions for future research, and dissemination plans.

5.2 Revisiting the research aim and question

The research aim was to explore the experience of clinical psychologists enacting compassionate leadership in H&SC settings. The research question was therefore:

> *How do clinical psychologists experience the enactment of compassionate leadership within the setting they practice in?*

Using semi-structured interviews with eight clinical psychologists and an IPA methodology, six GETs were formed, eliciting points of convergence and divergence, instead of group norms (Smith et et al., 2022, p.100):

- GET 1: Self-Compassion
- GET 2: Fostering psychological safety
- GET 3: A "courageous dance"
- GET 4: Deep empathy: Attunement and Embodiment
- GET 5: Misunderstood: "Fluffy", "Wafty", and unboundaried
- GET 6: Navigating uncompassionate systems

5.3 Summary of findings and implications per theme

Before turning to each sub-theme, it is important to clarify the analytic approach. Theories and models were prioritised where there was clear conceptual fit with participants' accounts and thematic focus, particularly where they offered explanatory value for leadership processes. Literature searches were conducted using iterations of each GET name combined with "leadership". In some cases, participants themselves guided this process: for example, explicit references to "good enough" were interpreted in context through Winnicott's (1953) good-enough mother theory, especially pertinent for those leading in child and family services. Psychological safety and courage were also terms directly named by participants, further supporting the selection of relevant literature.

Because compassionate leadership is inherently relational rather than existing in isolation, theories and models were also assessed for their relational applicability as well as thematic relevance. Reflexivity was central in this process. The author's background in clinical training and as a health manager meant prior familiarity with constructs such as transference, projection, and NHS practices around staff advocacy. These forms of prior knowledge were acknowledged reflexively and applied only where they illuminated, rather than predetermined, the analysis.

Theoretical ideas were therefore used in line with IPA as interpretative lenses that helped integrate idiographic accounts with wider conceptual understanding. Where possible, synthesis was attempted, but consistent with IPA's idiographic commitment, divergence across accounts was preserved rather than collapsed into a single norm, ensuring participants' voices remained central.

5.3.1 Self-Compassion

Participants' accounts positioned self-compassion as foundational to their ability to sustain compassionate leadership. Across narratives, self-compassion was described as both an inward-facing resource and an outward-facing ethic, enabling leaders to balance emotional demands, sustain relationships, and resist unsustainable pressures. Participants experiences could be understood through Gilbert's (2009) three-system affect regulation model, in which self-compassion activates the 'soothing system' to counterbalance the 'threat' (stress, self-criticism) and 'drive' (overwork, achievement) systems. Participants reflected on being caught in cycles of drive and threat with little room for recovery, and described conscious engagement in practices such as boundary-setting, reflection, self-forgiveness, seeking allies, and emotional regulation as ways of expanding their "green circle" (soothing system) which was an enabler of compassionate leadership. These findings echo evidence that self-compassion buffers against secondary traumatic stress (Crego et al., 2022) and sustains compassionate practice among healthcare professionals (Najmabadi et al., 2024). In particular, Liana's metaphor of *"filling my own cup"* encapsulates the conscious effort to self-soothe.

Reflective practice, a core competency of clinical psychologists appeared to function as a vehicle for regulating emotion (reducing a threat response) and preventing reactive leadership (reducing a drive response), and thus, sustaining self-compassion. In exploring self-compassion, participants appeared to utilise Schön's (1983) Reflection-in-action and on-action model, and this model was deemed to be a good fit of the participant experiences, with the author aware of this model via doctoral training. Pausing, self-enquiry, and noticing limits were described as essential for preventing reactive leadership and maintaining presence. Amir

spoke to having an awareness of his boundaries in the moment, recognising that "it's not all on me to sort everything" exploring how his leadership style has shifted from self-sacrifice to sustainability. Jamie similarly emphasised reflection-in-action regarding accountability where she used the phrase "practicing what we preach" and relationship repair, also using self-compassion as motivation, rather than self-criticism to achieve, which is supported in compassion research (Neff & Seppala, 2016).

At the same time, divergent accounts highlighted there were different pathways of enacting self-compassion. For Maria and Anjali, whose experiences were shaped by racism, sexism, and in Anjali's case motherhood, self-compassion was an intentional, effortful practice of preservation. Maria (reflecting in action) used reflective pauses to resist internalising microaggressions, highlighting how self-awareness of one's thoughts, emotions and behaviours can lead to increased self-compassion (Riccio, 2023). This resonates with emerging research that self-compassion can buffer the negative psychological impacts of discrimination (Li et al., 2022; Tucker, 2023). Anjali, who works with children and families, appeared to reflect on Winnicott's (1953) theory of the "good enough mother", rooted in psychoanalytic traditions of early attachment, which she reinterpreted being "good enough" as a professional ethic.. This protected against perfectionism and overextension, where she reflection on action that *"balls will be dropped*" without compromising care. Her account parallels evidence that unattainable expectations in healthcare contribute to burnout, compassion fatigue, and moral injury (Hollingsworth, 2024; Lövenmark & Hammer, 2023; West & Coia, 2019). Similarly on the idea of being good enough, Jamie noted the importance of self-forgiveness and normalisation of setbacks, which can also be interpreted as protection against perfectionist standards. This reflects self-compassion requiring holding negative self-relevant emotions in mindful awareness (Neff & Knox, 2016). In contrast, Michaela reflected on action that self-

compassion was readily accessible to her, grounded in a compassionate upbringing and structural privilege.

Synthesised together, these accounts illustrate that self-compassion can appear to be a constellation of practices whereby pausing, forgiving, feeling "good enough", boundary setting, repairing, and resisting collectively underpin sustainable compassionate leadership. Returning to Gilbert's (2009) model, these practices can be understood as deliberate activations of the soothing system in order to counterbalance the chronic overactivation of the drive and threat systems so common in healthcare contexts. Taken as a whole, these findings suggest that self-compassion enables leaders to remain grounded, resilient, hold realistic standards, and relational in contexts that are often emotionally depleting. However, the divergence across participants highlights that self-compassion is not an individual trait, but is mediated by upbringing, social position, and systemic structures. This underscores the importance of embedding organisational support, such as mindfulness-based self-compassion activities (Germer & Neff, 2019), protected reflection time, and compassion-focused supervision (NHS England, 2020c), as well as cultivating team-based compassion practices shown to benefit both staff and patients (De Zulueta, 2015; Kriakous et al., 2021). Without such systemic support, compassionate leadership risks depending on individual resilience, perpetuating inequities in who can sustain it.

5.3.2 Fostering Psychological Safety

Psychological safety is the belief that one can speak up without risk of punishment or humiliation and that teams are safe for interpersonal risk taking (Edmondson, 1999; Edmondson & Mortensen, 2014). Psychological safety is important in high-risk environments such as mental health settings, with benefits such as reduced errors, rapid learning, and

protecting staff health and wellbeing (Hunt et al., 2021). Fostering psychological safety emerged as a core behaviour of compassionate leaders, achieved through overlapping practices; cultivating anti-blame and non-judgemental cultures, building trust, humanising relationships, protecting teams, legitimising vulnerability, sharing power, and ensuring cultural differences were respected in the workplace.

Across accounts, leaders described counteracting the corrosive effects of blame cultures. Jamie and Maria actively resisted blame culture, instead modelling self-reflection, non-judgement, and accountability, prioritising dialogue over defensiveness. Jamie's approach in avoiding blame mirrors leaders who *attend* by *"listening with fascination"* and *understand* by resolving conflicts through dialogue rather than authority, which directly echoes the 'attending' and 'understanding' elements of the four behaviours of a compassionate leader (Kline, 1999; West, 2021). Maria directly referenced[9] Gilbert's (2009) three-system model to interpret how blame activates the threat system, heightening anxiety and fear. In response, she intentionally fosters a reflective, non-threatening environment to engage the soothing system. This interpretation resonates with research showing that protected emotionally safe spaces or forums such as Schwartz Rounds[10] can mitigate stress-related cognitive narrowing and empathy decline (George, 2016). By resisting blame, these leaders modelled psychological safety as both relational presence and systemic repair.

Trust and vulnerability were also emphasised as critical enablers. Lola's emphasis that compassion builds trust, is supported by Kahn's (1990) original research into psychological

[9] As per Maria's quote "*…so much in drive that it became like the red circle and blue circle were really big…"*

[10] Schwartz Rounds are structured, multidisciplinary forums for healthcare staff to come together to reflect on the emotional and relational aspects of their work. Designed to support psychological wellbeing, rounds help reduce stress, enhance empathy, and foster a shared understanding across professional roles. Evidence suggests they can mitigate hierarchical dynamics and improve staff cohesion by providing a safe space to process the emotional impact of care.

safety which indicated trust in interpersonal relationships was central in fostering psychological safety. Trust enabled individuals to risk vulnerability without fear of harm, with Lola's compassionate approach the scaffolding for trust and open communication. Similarly, within anxiety provoking multidisciplinary settings, Michaela and Liana voice concerns regarding workload and performance pressures, with Liana's prioritising emotional presence and modelling vulnerability. These behaviours align with ethical leadership practices shown to mediate psychological safety (Newman et al., 2017). However, Sonia's experience of hostility left her demoralised, defensive, and unable to access compassion for others, with evidence from healthcare settings indicating that organisational threat can reduce compassion for others, also understood through an overactive threat system (Gilbert, 2009; Henshall et al., 2018).

Participants also located psychological safety within structural inclusivity and cultural safety. Liana and Amir expressed how underrepresentation compounds feelings of isolation and vulnerability, where visibly seeing or knowing that other staff shared similar backgrounds to them could make them feel more psychologically safe. In relation to cultural safety[11], this emphasises creating environments where staff and service users feel their cultural identities are respected and valued, and where power imbalances are acknowledged (Lokugamage et al., 2023), thereby promoting inclusion and performance in line with compassionate leadership. Anjali facilitates an atmosphere of cultural safety in supervision through acknowledging differences in identity, power, and cultural and emotional realities of her team. By naming and addressing these dynamics, she modelled allyship and inclusive leadership,

[11] Cultural safety emerged as a way of overturning individual and structural racism experienced by colonised Māori peoples in New Zealand (Ramsden, 2002), and has gained traction within the workforce in recognition of workforce diversity.

moving beyond generic supervision toward protected reflective spaces and culturally safe and sensitive supervision (Curtis et al., 2019; Williams et al., 2020), in line with anti-racist practice. This expands Edmondson's (1999) original framing of psychological safety by showing that safety is not only interpersonal but also deeply entangled with equity and representation. Despite policy commitments, such as those responding to the "snowy white peaks" report (Kline, 2024a), inequities persist, and discrimination continues to impact staff mental health, job satisfaction, and retention (Rhead et al., 2021).

Transparency and power sharing emerged as mechanisms for psychological safety. Amir demonstrates understanding, a willingness to help, and empathy to the needs of diverse staff, and was transparent that he was unsure about the action needed. Maria intentionally relinquishes hierarchical power, allowing staff to raise concerns elsewhere if needed. Status and hierarchical power have been associated with inhibiting psychological safety (Edmondson et al., 2016). When leaders give autonomy, minimise hierarchical distance, and encourage participative decision making, team members feel empowered to contribute constructively (Applebaum et al., 2016; Ross et al., 2024).

Synthesised together, these accounts show that compassionate leaders foster psychological safety by creating conditions that soothe fear, build trust, and legitimise vulnerability, while simultaneously resisting systemic forces of blame, exclusion, and hierarchy. Returning to Gilbert's (2009) three-system model, participants described how threat-dominant cultures, whether rooted in performance pressures, racism, or hierarchical hostility, restrict compassionate capacity. By contrast, compassionate leadership creates "soothing system" conditions that sustain trust, inclusivity, and openness. Divergences between accounts, such as Sonia's defensiveness under threat versus Maria's and Anjali's

intentional modelling of transparency and inclusivity, highlight psychological safety's fragility and its dependence on both interpersonal behaviours and systemic support. These findings reinforce policy calls (NHS England, 2019a; Rao & Mason, 2023) for embedding protected reflective spaces, culturally safe supervision, and anti-blame cultures, underscoring the imperative to cultivate psychological safety not only as an interpersonal ethic but as a structural necessity for safe and effective care.

5.3.3 "A courageous dance"

Across participants, compassionate leadership was repeatedly as an active, morally based practice that requires repeated risk-taking, self-awareness, and strategic action, despite facing discomfort. The overall participant experiences could be encapsulated by Jamie's metaphor of a "*courageous dance*". Rather than treating courage and compassion as contradictory, participant interviews revealed how compassion and courage are linked: courage closes the gap between empathic understanding and ethical action. This synthesis draws together three analytic strands from the interviews (affective-cognitive processes; identity and authenticity; and organisational context/ resources) and integrates them with relevant theory to show how the "*dance*" is enabled, constrained, and routinised in practice.

A literature search on the topic of courage and decision making identified the contemporary dual-process model of courage (Chowkase et al., 2024) as an appropriate interpretive frame. Its central tenet, that affective arousal and reflective appraisal jointly drive courageous action maps closely onto participants' accounts of immediate emotional alarm followed by deliberative moral choice. Thus, this model was included to integrate idiographic IPA findings with a model that could underpin participant insight. In the accounts provided, Jamie's "*dance*" between empathy and action, and her "*leap of faith*" while feeling anxious,

Liana's willingness to disrupt team momentum to invite reflection, and Sonia's exposure in supporting minoritised staff all exemplify this process. The model highlights an 'approach-avoidance conflict', where leaders weigh the personal risks of acting (e.g. vulnerability, exposure, or professional backlash), against the potential for a prosocial or ethical outcome. Practically, these accounts suggest courageous leadership involves tolerating high arousal while engaging in deliberative reasoning about consequences for others and the system. Sonia's analogy to "*exposure therapy*" captures how repeated acts of courage gradually make vulnerability ("*stick my neck out*", Sonia) more bearable, a process supported by the literature regarding the act of acceptance and the impact on psychological health, where accepting uncomfortable emotions leads to greater wellbeing and effectiveness (Ford et al., 2018).

Second, the theme of courage is shaped by identity and authenticity. Lola's account of resisting assimilation and choosing a "*harder, longer slog"* to lead authentically as a black woman, and Sonia's commitment to her jewish identity highlight how identity-based courage resists conformity and aligns with core values. A literature search regarding stress within minority groups highlighted minority stress theory (Meyer, 2003), which posits that minoritised individuals face unique stressors from systemic discrimination, impacting wellbeing. While few empirical studies explicitly link Meyer's (2003) theory to leadership experiences, this seminal theory's mechanisms (vigilance, expectation of rejection, internalised stigma, coping and social support) map directly onto participants' descriptions of the added psychological cost of leading visibly from a marginalised position. For leaders from marginalised backgrounds, courage can mean exposing oneself to potential prejudice while affirming core values. Maria's acceptance of uncomfortable feedback as a moral stance similarly demonstrates courage as ethical risk-taking that protects others' agency. These dynamics connect to authentic leadership which is rooted in self-awareness, values alignment,

and relational transparency (Hoch et al., 2018), where courageous acts are more sustainable. Thus, authenticity not only motivates courage but shapes the form it takes (e.g. public acts of advocacy, modelling vulnerability, or deliberately tolerating discomfort).

Third, courageous leadership occurred when resisting organisational pressures. Liana's interruption of team momentum to *"stop, pause, and think"* and Jamie's reflection regarding staffing needs show that courage is enacted inside operational pressures and hierarchical dynamics. Maria also committed to hearing difficult feedback, even at personal discomfort, which reflects a values-based approach to power: prioritising agency and ethical responsibility over self-protection. Where systems provide reflective spaces, peer support, and psychological safety, leaders can more readily translate empathy into action and *"do hard things in a human way"* (NHS England North West, 2024). Conversely, when hostility or punitive cultures dominate, as Sonia described when faced with a scathing consultant, threat-system activation (in Gilbert's terms) constrains the capacity to act compassionately. In short, the "*dance*" is easier when the system soothes rather than amplifies threat.

Synthesising these strands, the "*courageous dance*" can be conceptualised as a competency with three interlocking features: (1) an affective-cognitive process that tolerates arousal while engaging deliberation; (2) identity-grounded authenticity that gives moral clarity and resilience to risk-taking; and (3) the resistance of organisational pressures that either enable or inhibit action. These features explain key divergences in participant accounts: why some participants (e.g. Sonia, Lola) describe courage as exposing identity and learning through repetition, while others (e.g. Jamie, Liana) described tactical bravery in team management. These differences map onto variation in individual resources, identity pressures, and systemic supports.

Implications follow directly. If courage is learned and situational, then organisations should not treat it as an individual trait to be admired in isolation. Practical support such as protected reflective time, peer consultation, leadership development that combines exposure with support, and policies that reduce punitive threat responses could make courageous compassion more sustainable and equitable. Importantly, supporting authenticity and representation (so leaders do not continually pay identity related costs for speaking up) is ethically necessary if marginalised leaders are expected to sustain courageous stances.

5.3.4 Deep Empathy: Attunement and Embodiment

This theme highlights how clinical psychologists as compassionate leaders connect with their staff not only cognitively, but also emotionally and somatically. Participants described profoundly resonating with colleagues' emotional states, sometimes physically embodying distress, pride, or vulnerability. This attunement enabled validation, containment and repair but also exposed leaders to vicarious shame, exhaustion, and the re-activation of personal histories. A literature search on attachment, embodiment and leadership identified theories and models chosen for their explanatory fit with mechanisms evident in participant accounts, conceptual relevance, and analytic usefulness. Consistent with IPA, these were applied as interpretative lenses to illuminate patterns across idiographic accounts and integrated where complementary.

Secure Base Leadership (SBL, Kohlrieser, 2012), rooted in attachment theory (Bowlby, 1969), helps explain the relational aims participants described. Leaders such as Anjali, Lola and Sonia enacted a secure-base function: containing distress, legitimising vulnerability, and encouraging staff to take developmental risks. This mirrors the secure attachment dynamic in which a caregiver's presence enables exploration and repair. Anjali's efforts to "*hold*",

"*protect*", and "*contain*" colleagues, and Sonia and Lola's comparisons of leadership to parenting, reflect this secure-base function. Crucially, participants emphasised that this base is enacted somatically (tone, pace, physical presence, regulated affect) rather than solely verbally. A leader's embodied calm or warmth directly scaffolded psychological safety and team disclosure.

Embodied empathy, as described by Amir, Lola, and Liana, aligns with somatic theories of emotion (Damasio, 1999), suggesting leaders not only observe but physically feel emotions. Amir's "warmth", Liana's "big" bodily panic, and Lola's sudden tearfulness illustrate how body-sensed cues function as early-warning signals of relational states. Interoceptive awareness (attending to bodily sensations) provides rapid affective information before full cognitive appraisal (Damasio, 1999; Fissler et al., 2016). When noticed and deliberately named, these cues facilitate regulation rather than reactivity. Participants diverged in their embodied experiences: for Liana, embodied vigilance appeared linked to both immediate relational cues and the cumulative effects of identity-related stress, while for Amir, warmth signalled co-regulation. Embodiment thus both provides information about team climate and operates as a regulatory mechanism prompting leaders to pause, contain, or intervene. Mindfulness practice offers a practical way of working with these somatic cues, helping leaders remain grounded and respond constructively (Brendel & Bennet, 2016).

Psychodynamic theory adds explanatory depth for the personal costs and ethical complexity of attunement. Sonia described "*vicariously*" experiencing colleagues' "*shame*" and "*frustration*", with her own history ("*I remember how demoralising it was*") amplifying the intensity. Such dynamics echo countertransference, where unconscious reactions shaped by personal history are triggered by others' affect (Obholzer & Roberts, 2019). Projection may

also be relevant; Lola's sense that "*she'd given it* [emotion] *all to me, and I felt it all*" suggests absorption of unspoken emotions. These processes illustrate how leaders can become emotional containers, consciously or otherwise, risking boundary blurring and over-identification. Awareness of these dynamics is essential, as shown in psychodynamic team and supervisory relationships (Hawkins & Shohet, 2012; Obholzer & Roberts, 2019).

In synthesising this theme, it is important to acknowledge divergence within participants' accounts and remain consistent with IPA's idiographic commitment, which resists collapsing varied experiences into a single norm. Across accounts, deep empathy in leadership emerged as a multidimensional process that is embodied, relational and psychodynamic. Leaders' bodies acted as both instruments and indicators, resonating with staff distress while carrying traces of their own histories. Embodied and interoceptive research helps explain how somatic signals inform attunement (Damasio, 1999; Fissler et al., 2016), while psychodynamic theory illuminates how countertransference and projection shape leaders' experiences (Obholzer & Roberts, 2019). SBL provides a unifying frame, showing how leaders offer safety, containment, and encouragement for growth (Kohlrieser, 2012). Taken together, these perspectives show that deep empathy can be grounding and relationally strengthening, but may also tip into exhaustion or reactivation of personal histories. Honouring these divergent pathways allows the group experiential theme to reflect complexity while generating a coherent conceptual account.

This sub theme discussion carries several implications for healthcare leadership. Firstly, relationally attuned leaders fosters psychological safety, team cohesion, and trust, all of which are associated with improved staff wellbeing and patient outcomes (Edmondson, 1999; West et al., 2020). To sustain this, leaders should have protected spaces for processing

embodied countertransference and projection, such as psychodynamically informed supervision or exploration of leader attachment styles (Cartmell, 2020). Second, organisations should also safeguard reflective forums such as Schwartz Rounds and mindfulness-based interventions (Conversano et al., 2020), allowing emotional experiences to be integrated rather than enacted, thereby protecting emotional capital. Finally, leadership development could include training in interoceptive awareness and deliberate regulation (Germer & Neff, 2019; Fissler et al., 2016), equipping leaders to notice and respond to somatic cues with reflection. These supportive structures must be matched by systemic action on representation, workload and cultural safety; otherwise deeply empathetic leaders risk boundary erosion, emotional exhaustion, compassion fatigue, secondary traumatic stress, and burnout (Marshman et al., 2022; NHS Employers, 2022; Sutton et al., 2022).

5.3.5 Misunderstood: "Fluffy", "Wafty", and Unboundaried

A central finding of this GET is that compassionate leadership is frequently misunderstood, either as a lack of rigour or as permissive leniency, and that these misunderstandings are amplified when enacted by those who do not fit historical westernised leadership archetypes (younger leaders, women, and people from the global majority). Participants' accounts expose two interlocking processes: (1) *stereotypic undermining*: where compassion is branded as "*soft*", "*naïve*" or "*floaty*" (Jamie, Lola, Liana, Maria); and (2) *practical misapplication*: where compassion without explicit boundaries or accountability produces perceptions of unfairness and operational risk (Amir, Sonia, Michaela). Both processes reduce the credibility and utility of compassion as a leadership approach.

As the majority of participants were female who described feeling treated unfavourably, a literature search regarding gender, leadership and prejudice highlighted Role

Congruity Theory (Eagly & Karau, 2002), which provides a coherent explanatory frame for the first process. Role Congruity theory proposes that prejudice arises when there is a perceived clash between the stereotypes of a social group (e.g. women) and the traits associated with a social role (e.g. leadership), leading to bias and reduced acceptance of individuals in those roles. This theory had conceptual fit, empirical standing and was analytically useful in understanding participant accounts. Participants reported that gendered and racialised expectations delegitimise compassionate behaviour in leaders who do not match the masculine and authoritative image of leadership: "being compassionate is seen as being "*too nice*" or being a bit "*naïve*" (Lola), and women may be penalised (feeling "*invisible and dismissed*", Maria) for violating stereotyped norms or for failing to conform to expectations of "*niceness*" (Maria). It could be the case that deep enmeshment and value alignment within healthcare systems is still developing, as Jamie stated "*older systems*" appear rigid and do not take compassionate leadership seriously, and instead is seen as "*wafty*" and "*fluffy*". These experiences, supported by recent policy and workforce analyses of bias in healthcare leadership where it has been found that women in healthcare leadership are undermined through stereotyping, unconscious bias, racism, and structural discrimination (Chand, 2023; Haines & McKeon, 2023; NHS Confederation, 2022b). Research on these dynamics within clinical psychology remains limited (Corrigall, 2015).

The second process concerns how compassion is operationalised. Participants repeatedly indicated that compassion requires boundaries and accountability: "*Yes, compassion important, but not to where people can just feel like they can treat us how they want*" (Amir). Sonia's frustration about perceived "*advantage-taking*" when policies are inconsistently applied illustrates that compassion unaccompanied by transparent norms risks perceived unfairness and resentment. Lola also suggested that it was possible that leaders

could get stuck in problem saturation which hinders them from taking action. These accounts align with West et al.s (2020) notion that:

"Compassionate leadership does not involve compromising our commitment to good performance management, having difficult conversations, making radical changes or being able to challenge the status quo" (West et al., 2020, p.80).

Michaela and Sonia's experiences demonstrate how overly lenient policy application could be perceived as inequitable and advantage-taking, creating resentment and division within teams, rather than cohesion. Despite Sonia explaining her balanced approach, colleagues still perceived her as *"too soft"*. Their accounts highlight the tension between individual compassion and collective accountability.

Synthesising these threads produces two integrated insights. First, the credibility of compassionate leadership is socially mediated: who enacts compassion matters, because gendered and racialised schemas (Role Congruity Theory, Eagly & Karau, 2002) shape whether compassion is interpreted as strength or weakness. Second, compassion is a practice with form, not a free-floating idea: it is effective when paired with clear boundaries, transparent processes, and collective accountability. The divergence across participants, with some emphasising reputational undermining (Jamie, Lola, Liana, Maria), others emphasising operational risk (Amir, Sonia, Michaela) is therefore not contradictory but complementary: they identify different points of failure that together explain why compassion is often misunderstood in H&SC settings.

To address both perception and practice, interventions could operate at three levels. At the individual leadership level, leaders could be supported to articulate compassionate practices as structured approaches (e.g. "compassionate boundaries" scripts, coaching in

difficult conversations), and to develop the political skill to translate compassion into credible action. At the team level, organisations could methodise transparent policies for applying compassionate responses and protect reflective spaces where staff can discuss tensions (reducing perceptions of arbitrariness). At the systemic level, anti-bias and representation strategies are essential: Role Congruity dynamics will not shift without targeted work on recruitment, promotion, and cultural change (Kline, 2024b; NHS England North West, 2023; Rao & Mason, 2023;). Embedding compassionate leadership in induction, offering coaching on policy-aligned compassion, and strengthening leadership preparation (e.g. integrating compassionate leadership competencies into doctoral training; DCP, 2021) could help normalise compassion as a credible, practicable approach rather than dismissed as a "*wafty*" and unboundaried.

5.3.6 Navigating uncompassionate systems

The theme "uncompassionate systems" highlights how compassionate leadership is shaped, and often constrained, by the broader organisational ecology. While participants described modelling compassion, they also made it clear that system-level structures, cultures and values ultimately define the boundaries of what is possible: as Maria put it, *"it's a system responsibility, not an individual one"*. Participants described repeatedly negotiating team norms, service-level constraints, managerial priorities and cultural scripts that either enabled or eroded compassionate practice. Some leaders (e.g. Michaela, Maria) could protect teams and create reflective space, while others (e.g. Sonia, Liana) encountered hostility, tokenistic initiatives, or organisational impasses that sapped their capacity to lead compassionately.

Bronfenbrenner's ecological systems theory (1979) can be used to synthesise findings as it was a strong conceptual fit for the theme and offered a method of organising participants

experiences across various system levels. Reflexively, prior frequent exposure to the model during doctoral training sensitised the author to its relevance, but selection was confirmed by the model's clear mapping onto participant accounts. The theory distinguishes the microsystem (teams), meso/exosystem (inter-team relations, managerial processes and institutional policies), the macrosystem (professional norms, resourcing regimes) and the chronosystem (temporal processes such as austerity cycles, reorganisations and COVID-19) that shape how other layers operate over time. Compassion therefore cannot be sustained by individuals alone; it must be embedded across layers.

At the microsystem (team) level, Michaela's team exemplified a local ecology supportive of compassion: psychological safety, reflection, open dialogue, and reciprocity meant team members supported each other, redistributed workload, with empathy and trust underpinning team dynamics. This reflects the notion of 'compassionate systems', where compassionate practices are embedded into everyday interactions and reinforced by role modelling and relational contagion (Ali & Terry, 2017; West & Chowla, 2017; West et al., 2017). Jamie, Amir, Liana and Lola also described how compassionate practices are reinforced via similar ripple effects: "*You pay it forward*" (Amir), where legitimised compassion in one team proliferated across departments (mesosystem), enhancing collective wellbeing and resilience (Östergård et al., 2023; West et al., 2020).

However, most participants described structural and cultural obstacles at the exosystem level. Systemic inflexibility, bureaucratic inertia, and misaligned priorities were seen as barriers to compassionate leadership (De Zulueta, 2015). Sonia's frustration with "*impasses*" for her staff leaving her hands tied, and Maria's scepticism of tokenistic "compassionate leadership training" highlight how structural constraints at the exosystem

level erode morale and foster cynicism. When compassion is reduced to superficial gestures or performative civility, it risks alienating staff and undermines authentic connection. Misalignment between exosystem and macrosystem levels can also make systems feel uncompassionate. Amir's struggle to balance service demands with staff wellbeing, and Lola's account of *"going against the tide"* reflecting a clash between compassionate values and dominant organisational priorities. Thus, misalignment between system layers can erode morale and oppose how compassionate leadership operates (De Zulueta, 2015; West et al., 2020).

Liana and Sonia's accounts of constant *"firefighting*" and acute time pressure illustrate how interactions between microsystem, mesosystem, and exosystem (team demand, formal procedures, managerial brick-walls) constrain the space necessary for reflection and care. Liana pleas for spaces to show emotion, which indicates compassion should be visible (or felt) in daily decision making and emotional expression should be legitimised. Anjali queried service inaccessibility and fragmentation highlights mesosystem-level disconnects that make it difficult to feel compassion across organisational boundaries. And, as social care staff are slightly outside of direct NHS structures, compassion leadership must therefore permeate through another organisational boundary. Jamie, at a macrosystem level, observes that compassion is easier to sustain from a *"helicopter view"* than amid frontline *"chaos"* highlights the inequity in who is privileged with compassion depending on which part of the system one's role is located in. At the macrosystem level, these dynamics are shaped by dominant professional norms such as prioritising productivity and risk-avoidance over reflective practice, which normalises fast decision-making and delegitimises time for reflection. The chronosystem further compounds this: long-term policy legacies, austerity cycles, repeated reorganisations and events such as the COVID-19 pandemic produce temporal inertia, so that

even well-intentioned local practices struggle to be sustained over time. Lola makes a call for compassion to be reflected in time structures when she asked for mindful systems.

A synthesis of this sub theme could suggest three interdependent priorities across system levels. At the microsystem (team) level, routinise and protect reflective practices (team reflection, clinical supervision, Schwartz rounds) and trauma informed practice (Sweeney et al., 2018) so teams can process emotional labour, repair ruptures and sustain presence with visible leadership and modelling. At the meso/ exosystem level, realign managerial processes with humane practice by calibrating workload and staffing, embedding clear "compassionate boundaries" into operational policy, and creating rapid cross-service escalation routes that reduce blame escalation and enable timely problem-solving. Culture that "trickles down" should legitimise emotional expression and self-compassion for staff, not just patients. Without multi-level alignment, compassionate leadership risks becoming performative or unsustainable, placing excessive pressure on individuals (Gabriel, 2015). At the macrosystem level, organisations should hold themselves publicly accountable: align values, policies and resourcing so that compassionate leadership is legitimised and sustained rather than symbolic, while moving beyond individualised notions of leadership (Tierney et al., 2019). As the chronosystem reminds us, systemic patterns left unchallenged will continue to shape healthcare cultures over time, undermining staff wellbeing, retention, and the quality of compassionate care.

5.4 Reflexive return regarding GET discussion

Throughout the discussion of GETs I intentionally kept my personal lens out of the GET level syntheses to foreground participants' voices and preserve the idiographic commitments of IPA. The analytical sections above therefore present interpretations driven by participants'

language and meaning-making. In this concluding reflexive return (from my statement of positionality in section 1.2, reflective diary extracts in appendix 1, and exploratory noting examples in appendix 8), I offer a reflective account of how my situated standpoint shaped attention and interpretation, to make explicit how my experience may have informed my analysis.

During doctoral training, I was exposed to reflective practice models (Schön, 1983) and systems theory (Bronfenbrenner, 1979), which provided additional conceptual tools that felt relevant for making sense of participant accounts. This prior learning of relevant knowledge meant I could consider their fit for theme construction, and utilised supervisor checks to ensure these were helpful additions for GET discussion.

Professionally, my NHS GMTS leadership experience sensitised me to organisational dynamics such as blame cultures, caseload pressures, discrimination, and the practical constraints of embedding reflective time. This familiarity made me aware of participants' accounts of psychological safety and operational pressures; I found myself recognising stories that illuminated how systems either enabled or blocked compassionate practice. Reflexively, I took care to test these resonances against the transcripts and to subject my exploratory notes to supervisory scrutiny so as not to conflate prior knowledge with participants' meanings, which helped me to not intentionally privilege some ideas over others.

Culturally, my upbringing as a practising Hindu, in which compassion ('Daya' and 'Karuṇā') is framed as a lived ethical practice, sensitised how I heard narratives about duty, care and moral responsibility. This perhaps made me more receptive to the "courageous dance" GET: I personally related to the moral imperative to act compassionately even when it is risky. As a global-majority male completing clinical training and working in contexts where

leadership archetypes are often white, middle-class and female, I also recognised an embodied affinity with accounts of underrepresentation and the emotional labour of belonging (for example, Lola and Maria's reflections). At times this affinity produced strong empathic resonance; at other times it risked projection. In supervision I reflected on occasions when participants may have been candid because they perceived a shared understanding, a dynamic I noted and actively checked. I also wonder if Hinduism had sensitised me to the GET "Deep empathy: embodiment and attunement", as compassion in Hinduism encourages sensitivity to others' suffering and relational action to alleviate it. I had always been encouraged in my upbringing to help others, and perhaps this experience had helped me conceptualise deep empathy, though again I followed an a clear idiosyncratic analysis of transcripts and can feel confident within myself I let this GET develop based on participant accounts. Overall I believe understanding compassion through Hinduism gave me added motivation and understanding in selecting this topic, though I do not believe it unduly influenced or forced my analysis in any direction.

Similarly, I have repeatedly encountered a conflation of compassion and kindness in my clinical and leadership experiences, where in general avoiding accountability, some taking more responsibility, and some seemingly having no consequences for repeated acts. My felt sense of injustice at this pattern sharpened my reading of the theme regarding compassion is misunderstood. I took care not to let my inner frustration shape the analysis, by taking an idiosyncratic approach to exploratory noting, returning repeatedly to the transcripts, and utilising the IPA quality checks to confirm this theme was present across multiple participants rather than being my impression alone. This gave me confidence the theme is grounded in participants' accounts, not in researcher projection.

These positional influences produced an immediate affective response for me. I found "psychological safety", "a courageous dance", and "misunderstandings of compassion" particularly resonant, both because they matched things I had seen in practice and because they intersected with identity experiences (race, gender, age). By contrast, the GETs of "self-compassion", "deep empathy", and "uncompassionate systems" provoked less personal reaction and less self-checking, as these felt intuitive and grounded in the data, rather than any internal connection. I did not find myself instinctively *feeling* these in the same way, which may have created a differing analytic stance (more descriptive, less advocacy-driven).

Overall, returning to my lens clarifies two practical points. First, where my lived experience aligned with participants' accounts it sharpened my sensitivity to particular dynamics (e.g. identity-related costs of courageous action), but it also required deliberate checking so that I did not overextend interpretation beyond what participants said. Second, where I felt less resonance I intentionally allowed the data to lead, avoiding a forced fit with preconceptions. This balanced reflexive practice strengthens confidence that the themes represent participants' lived meanings, albeit interpreted through my standpoint.

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5.5 Recommendations

The implications from the prior sections can be translated into recommendations. Each recommendation is linked to a GET, underpinned by Ecological systems theory (Bronfenbrenner, 1979) which locates compassionate leadership across the H&SC system (GET 6). These recommendations in Table 16 are not an exhaustive list, but for system members and leaders to consider as appropriate.

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Table 16

Table of Recommendations

Level	Recommendation / Action	GET	Theory/ Findings
Individual	Embed mindfulness-based self-compassion, reflective practice, and boundary-setting into daily leadership routines	1	Mindfulness (Germer & Neff, 2019); Three-System Model (Gilbert, 2009); Reflective practice (Schön, 1983); "Good Enough" (Winnicott, 1953); People plan (NHS England,2020); Compassionate leadership framework (NHS England North West, 2024)
Mesosystem (Inter-team)	Compassion focused Supervision and/ or reflective practice within doctoral training courses, and local healthcare systems to offer this to qualified staff	1	
Individual	Promote self-forgiveness and normalisation of setbacks through supervision and training.	1	Neff & Knox (2016); Neff & Seppala (2016); Riccio (2023)
Microsystem (Team)	Establish regular, protected reflective spaces (e.g. Schwartz Rounds, peer supervision) that focus on psychological safety and emotional processing.	2	Edmondson's Psychological Safety (1999); Three-System Model (Gilbert, 2009); Secure Base Leadership (Kohlrieser, 2012); People plan (NHS England, 2020); Rao & Mason (2023)
Microsystem (Team)	Model and reward anti-blame, non-judgemental, culturally safe and inclusive cultures; prioritise trust-building and power-sharing.	2	Applebaum et al. (2016); Bailey & West (2022b); Kahn (1990); Kline (1999); Lokugamage et al., (2023); Newman et al. (2017); Ramsden, (2002)
Mesosystem (Inter-team)	Embed protected time for leadership reflection and peer consultation across services. Supports resilience	3	Courageous/ Authentic Leadership (Alyyani et al., 2018; Avolio & Gardner, 2005; Raso, 2019; West et al., 2015); Dual-Process Model of Courage (Chowkase et al., 2024)
Mesosystem (Inter-team)	Develop clear escalation pathways for raising concerns and feedback, ensuring psychological safety during conflict.	3	People Plan (Freedom to speak up guardian) (NHS England, 2020)
Exosystem (Organisation)	Mindfulness practice resources focusing on the mind-body connection to be available to trainees and qualified staff.	1	Mindfulness (Germer & Neff, 2019); Neff & Knox (2016); Neff & Seppala (2016); People Plan (NHS England, 2020)

Level	Recommendation / Action	GET	Theory/ Findings
Mesosystem (Inter-team)	Focus on experience of transference within Supervision and MDT experiences	4	Systems Psychodynamics (Obholzer & Roberts, 2019)
Exosystem (Organisation)	• Ensure visible, authentic senior leadership modelling of compassion, vulnerability, and inclusivity. • Culturally sensitive supervision training • Compassion focused reflective practice groups amongst trainees and qualified staff. • Local Inductions- to communicate that compassionate leadership is the aim	4,5	Secure Base Leadership (Kohlrieser, 2012); Somatic Theories (Damasio, 1999); Compassionate leadership framework (NHS England North West, 2024)
Exosystem (Organisation)	Integrate anti-blame and psychological safety metrics into performance reviews and organisational KPIs.	2	Edmondson et al. (2016); West (2021); WRES (NHS England, 2024a); LTP (NHS England, 2019a)
Macrosystem (System)	• Standardise and resource protected time for reflection, supervision, and leadership development across NHS trusts. • Compassionate leadership coaching/ workshops. Local system leaders to facilitate space to run these. • Clear articulation of what compassionate leadership is.	5,6	Ecological Systems Theory (Bronfenbrenner, 1979); People plan (NHS England, 2020); Systems Psychodynamics (Obholzer & Roberts, 2019)
Macrosystem (System)	Promote and resource collective, system-wide approaches to compassionate leadership, not just individual development.	5,6	Compassionate leadership framework (NHS England North West, 2024); West et al. (2020); West & Bailey (2023).
Macrosystem (System)	BPS Guidance/ Clinical psychology leadership development framework to explicitly embed compassionate leadership as a leadership competency - Self-compassion - Fostering psychological safety - Courage - Attunement	1-6	PPN (2020); Leadership development for clinical psychologists (DCP, 2021); Rao & Mason (2023)

5.5 Strengths and limitations

This study is, to the author's knowledge, the first documented exploration of how mental health professionals, specifically clinical psychologists, enact compassionate leadership within UK H&SC. It contributes to contemporary leadership discourse linking compassionate leadership to self-compassion, psychological safety, courage, and attunement. In addition, the study indicates compassionate leadership could be more clearly understood, and highlights that compassionate leadership is a system-wide responsibility.

Including clinical psychologists in leadership within NHS and local authority settings brings an underrepresented, yet valuable, perspective to leadership culture reform. Furthermore, the participation of six individuals from global majority backgrounds and seven females supports the ongoing decolonisation of leadership research, challenging the predominance of 'white male' perspectives, and perspectives regarding authority in pressurised situations.

Methodological rigour was maintained through strict adherence to IPA principles, including a homogenous and appropriately sized sample. Reflexivity was embedded throughout the research process via the use of reflective research teams, a reflexive diary, idiosyncratic transcript analysis, and good consensus agreement regarding quote selection and theme construction, all of which meet established IPA specific standards for qualitative research quality (Nizza et al., 2021; Smith, 2011; Smith et al, 2022, evidenced in section 3.8).

A further strength of this study is the researcher's positionality, which brought professional insight and cultural motivation into the topic of compassionate leadership. An NHS leadership background and Hindu upbringing offered sensitivity to issues such as psychological safety, courage, and moral responsibility, enabling a richer engagement with

participants' accounts. At the same time, this personal lens requires careful consideration, as prior knowledge and lived experience could have influenced interpretation. Reflexive practices as mentioned in the paragraph prior, were therefore essential to safeguard against bias and ensure that findings remained grounded in participants' voices.

Despite its contributions, the study has several limitations. Firstly, the GETs are inherently subjective, as some participant quotations could overlap with multiple themes, reflecting the multifaceted nature of compassionate leadership. While multiple measures were taken to mitigate researcher bias, the double hermeneutic inherent in IPA means findings may differ with another researcher.

Secondly, in applying a critical realist lens, while it highlights underlying mechanisms influencing compassionate leadership, it may underplay the relational and interactional nature of how compassion is actually expressed and experienced. Compassionate leadership is not a fixed trait or purely an outcome of structural forces, it is also performed in the moment and co-constructed through relationships, meaning it emerges dynamically through interactions with others. This nuance may be missed when focusing primarily on hidden mechanisms or broader systemic influences.

Third, participants were not invited to review their interview transcripts or the interpretations of their quotes. While the researcher sought to bracket preconceptions, participant checks may have enhanced the reliability of the interpretations, particularly given the depth and candidness of disclosures, arguably reflecting the relational openness associated with authentic leadership. In addition, as a global majority male researcher engaging with leaders of varied genders, ages, and ethnic backgrounds, there is diversity within diversity; the researcher's standpoint may have shaped the dynamics of disclosure and

the way accounts were interpreted, with different nuances perhaps emerging had the researcher held a different identity.

Fourth, the study's findings are based on a small sample of clinical psychologists in leadership roles. Although IPA does not seek generalisability (Nizza et al., 2021) and the findings appear promising with supportive evidence, more research is required from broader allied health colleagues to further develop discourse and recommendations regarding the enactment of compassionate leadership.

Finally, the tone of the findings, which emphasises the challenges of enacting compassionate leadership, may reflect ongoing systemic pressures within H&SC. Few participants shared some positive outcomes associated with compassionate leadership, which went unexplored in the present study.

5.6 Directions for future research

This study highlights several avenues for future inquiry. Leadership within clinical psychology remains underexplored, with much of the literature limited to unpublished theses. Given the changing post-pandemic healthcare landscape and ongoing system pressures, clinical psychologists could be involved in research that refines the theoretical framework for compassionate leadership and within the profession (DCP, 2021; Evans, 2022; Gomes, 2015).

This study included a high proportion of global majority participants, with many reflecting on how adverse experiences shaped their leadership. Future work could explore how both adversity and privilege (e.g. whiteness, seniority, class) inform compassionate leadership practice. Additionally, exploring the male experience of compassionate leadership may help move beyond heroic or individualised models often aligned with stereotypically masculine traits.

Psychological safety emerged as a foundational construct. Research could examine how trust, cultural safety, and power-sharing impact psychological safety (Edmondson et al., 2016; Hunt et al., 2021) within clinical psychology-led teams. A multi-perspective (e.g. including supervisees or colleagues) or longitudinal approach, could offer deeper insight into how psychological safety is experienced.

Another direction involves examining the outcomes of compassionate leadership, particularly whether it translates into improved service-user care (West & Chowla, 2017). This could strengthen its value, as healthcare ultimately centres around service-users, and should demonstrate a return on publicly invested funds.

Future studies might also evaluate interventions beyond mindfulness to support compassionate leadership, such as compassion-focused supervision, self-compassion strategies (Germer & Neff, 2019), or training in mind-body attunement (Brendel & Bennet., 2016). Pilot studies could explore the effects of compassion-focused supervision on compassionate leadership ratings, expressions of vulnerability, or team climate.

Trauma-informed approaches and compassionate leadership both prioritise psychological safety, trust, and relational sensitivity. Future research could investigate possible synergies between compassionate leadership and trauma-informed practice within organisational cultures, as one participant referenced a link to their own service being trauma-informed.

Finally, compassionate leadership is a system effort and research should also focus on compassionate system development, rather than solely locating this within individuals (Howick et al., 2024; Tierney et al., 2019).

5.7 Dissemination plans

Dissemination plans are summarised in Table 17.

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Table 17

Dissemination plans

Audience	Format	Purpose	Timeframe	Notes
Participants	Full copy of thesis	Opted in to receive copy	September 2025	Ethical responsibility.
University of Hertfordshire DCLINPSY course	Full copy of thesis	Share learning. Inform leadership module content.	October 2025	TBD with leadership module lead. Trainee CPs report feeling underprepared for leadership.
University of Hertfordshire Research conference	Powerpoint and Verbal presentation	Academic responsibility to disseminate research output.	August/September 2025	
Relevant journal • BPS Division of clinical psychology, • Journal of healthcare leadership.	Journal submission	Formal dissemination	Requires discussion regarding support available to do this, and timescale.	It may be possible to split the findings into multiple research papers/ multiple results papers, for example one paper focusing on self-compassion in relation to compassionate leadership, and another on bravery in compassionate leadership.
BPS discussion/ reflective Piece	Article (s)	Spread awareness of compassionate leadership	October 2025 onwards	Requires further discussion with principal supervisor about co-constructing this or if I lead this.
Colleagues/ Peers	CPD presentation	Share learning. Advance the profession.	Ongoing	This is learning and skill that is applicable throughout my career that will stay with me.
Colleagues/ Peers	Role modelling,	I have learnt skills in enactment which I can apply	Ongoing	My participants shared their internal dialogue about how they enact CL, which is very helpful to role model and apply.

Audience	Format	Purpose	Timeframe	Notes
	informal support			
Local Directors of Psychology, Chief Psychological professions officer	Full copy of thesis	Dissemination of my research to local directors of psychology services and chief people officers who should be given the opportunity to support the roll out of compassionate leadership principles within the psychological workforce.	September 2025	Circulation possible once final grade/pass is given. Will write a brief introduction regarding who I am and why compassionate leadership should hopefully interest them.

[END - REFERENCES AND APPENDICES FOLLOW THIS PAGE]

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Appendices

Appendix 1: Reflective diary extracts

Year 2 early prep for MRP: Sufficient internal motivation for this topic

XXXXXs comment about the size and scope of a thesis really resonated with me. It made me ponder my motivations and what truly drives me. While the diabetes topic is intriguing, I feel nervous about if I would be good enough, and I have more passion for my personal interests in business and leadership. I've always been drawn to the idea of leadership, but it's a complex…thing. I admire entrepreneurs and their journeys, and I aspire to lead, but I struggle to articulate why. Perhaps it's the challenge? the opportunity to make a difference? or simply the desire to progress?

My time in Leeds was a turning point. XXXXX, XXXXX, and XXXXX introduced me to the concept of personalised people management and compassionate leadership. It was a transformative experience, and I felt empowered to drive culture change. The blend of theory and practice was intriguing, and I could tangibly feel the positive impact of this

leadership style. However, the challenges of implementing these ideals within a pressured healthcare system were undeniable.

Hhmm, this topic resonates deeply with me. I'm genuinely invested in exploring the intersection of compassionate leadership and healthcare. By involving clinical psychologists, I think I can contribute to healthcare leadership practices and ensure clinical psychologists are recognised as leaders as we seem to be forgotten in a lot of healthcare leadership research. This prospect is incredibly motivating, and I'm eager to contribute to this emerging field.

Epistemological stance: Maybe social constructionism could work?

As I delve deeper into my research, I'm aligned to the critical realist epistemological stance which acknowledges the existence of a real world, independent of our perceptions, but shaped by unobservable structures and mechanisms. For instance, while the subjective experiences of healthcare professionals are undoubtedly important, they are also shaped by objective conditions such as workload, staffing levels, and organisational policies that impact leadership response.

However, I'm intrigued by the value of a social constructionist perspective, which emphasises the social and cultural factors that shape our understanding of reality. I wonder if this means that our understanding of compassionate leadership is influenced by social norms, cultural values, and historical context. Perhaps it can also help us to identify the power dynamics that shape healthcare practices and to challenge dominant discourses that may perpetuate inequities. I suppose a social constructionist perspective can help us to understand how these mechanisms are socially and culturally constructed. It was interesting

to reflect on taking a different approach, but I am happy with a critical realist stance, and so is the research team.

Completing the first 2 interviews

Reflecting on the first two interviews, they felt quite lengthy. This is likely due to the idiosyncratic nature of IPA, where each participant's experience is unique and requires deep exploration. However, I couldn't shake the feeling that some of my questions may not have been as relevant as I had hoped. I had discovered this after transcribing the interviews, being careful not to analyse them as per IPA methodology. However, the brain naturally will try to make a little bit of sense of the data, and that's when I initially began to feel some of the data was not as relevant. Perhaps my initial nervousness about gathering enough "right" data led me to over-prompt. However, what is "right" data?

To streamline future interviews, I'll refine my interview introduction to highlight the IPA interview may not seem like a natural conversation and to not be put off by this, as it can involve pauses or moments of silence. I'll reassure participants that it's okay to take their time and that their thoughts, feelings, and interpretations are what I am hoping to elicit. By setting clear expectations from the outset, I hope for the interviews to feel less like a checklist of prompts.

I'm glad this opportunity arose early to reflect on my approach and make helpful adjustments. This learning experience will enhance my confidence in my future interviews, and act as reminder that there is no "right" data, I am guided by the participants too.

IPA data analysis- Jamie

Today I began exploratory noting on Jamie's transcript. Their account felt particularly emotionally charged; there were moments when they described *"a courageous dance"* and *"being brave"* after feeling vulnerable when needing to challenge more experienced and senior staff. I noticed myself resonating with this, as I too have felt vulnerable wanting to defend my own leadership decisions. This made me pause and consider, am I empathising, or projecting? Or am I getting too attached to her story?

This is the tension of IPA, the double hermeneutic. I am trying to make sense of them making sense of their own experience. But my lens is shaped by who I am, my values, and actively looking for meaning in her stories. I find myself wondering if I'm leaning too quickly into interpretations that reflect my own ideals of what compassionate leadership "should" look like.

To stay grounded, I returned to the transcript, reading the participant's exact words before and after that moment. This helped me reframe the comment not as a sign of vulnerability, but as a turning point, a shift in their understanding of their role. It reminded me to stay close to their language, rather than interpreting through my own assumptions.

I also noticed that some experiential statements I wrote blurred descriptive and conceptual levels too quickly. I'll make a note to return and check whether these actually stem from the transcript, or if I've jumped ahead and forced connections. IPA requires patience, letting the meaning emerge, rather than imposing it. I am reminded that interpretations must be both empathic and critical, and balancing both is the challenge, and the richness of this work.

IPA data analysis– Sonia

As I analysed Sonia's interview, I found myself nodding along more than I expected. She spoke about the limits of compassion, describing moments when colleagues seemed to expect endless emotional availability, or when helping began to feel like enabling, and it resonated a lot with me. Rather than being surprised or conflicted, I actually felt a deep sense of recognition. There was something refreshingly honest in what she said, and it struck me how rarely this side of compassion is talked about. It can feel almost taboo to admit that compassion has boundaries, especially in healthcare settings where selflessness is often idealised. I found myself thinking…. this isn't a lack of compassion- this is what *sustainable* compassion looks like.

This was a moment where the double hermeneutic felt aligned. I was making sense of their experience through my own, but rather than clouding the data, it seemed to help me stay with the emotional truth of what they were sharing. I still made sure to check myself, returning to the transcript, making sure the experiential statements I wrote weren't too heavily influenced by my own views. But the resonance helped me hear the *meaning* in what she described more clearly…. that compassion without boundaries risks burnout, and that feeling guilt over that is part of the very misunderstanding we need to challenge. IPA can be powerful, it lets space exist for uncomfortable truths, and acknowledges that sometimes the most compassionate thing a leader can do is say, "enough."

IPA: Culture and compassion supervision reflections (summarised)

In response to my supervisor's feedback, I reflected more closely on how participants' cultural and religious backgrounds might have influenced their understanding of compassion. Several participants spoke about their families as early sources of compassionate templates, one described a compassionate family environment as role

modelling, while another highlighted the influence of their sisters. These accounts stood out to me, because they contrasted with my own experience of growing up with fewer compassionate role models. This difference made me more aware of how upbringing and cultural context can shape compassionate capacity, and how it is expressed in leadership.

Some participants reflected on being seen as naive due to perceptions of youth when they showed compassion, which was different to me, as although I am somewhat junior, I have felt empowered, though for other reasons. Others connected their compassionate leadership to a desire to challenge sexism or racism, to restore fairness. These themes naturally struck a chord with me, and I took a step back to assess if I was interpreting accounts through the lens of my own values and experiences.

This prompted me to consciously revisit the IPA principle of bracketing, to acknowledge my own positionality and consider how it might be shaping my interpretations. Rather than trying to eliminate my perspective entirely, I aimed to hold it in awareness, using it to deepen empathy while also questioning where it might be influencing meaning-making. This reflexive process helped me to consider participants' narratives within their own socio-cultural and spiritual frameworks, rather than interpreting them solely through mine. Ultimately, this reflection kept me grounded and holding an awareness for compassion as culturally situated and a personally meaningful concept, shaped not just by individual psychology but by broader social histories, including religion, gender, and race.

IPA: Participant – researcher dynamic (summarised)

As I continued analysing the interviews, I reflected on the level of openness many participants showed. They spoke candidly about racism, sexism, and personal struggles with compassion. I began to wonder whether, as a global majority male researcher, my identity

contributed to this openness. Would participants have been as forthcoming with someone from a different background? It's hard to say, but I sensed that a shared experience of marginalisation, whether real or perceived, may have fostered a sense of trust or safety in the space we co-created.

My supervisors commented on the richness of the data, particularly the depth of quotes. This prompted me to reflect on what qualities supported that dynamic. I had approached the interviews with empathy, active listening, and a commitment to holding space without judgement, skills rooted in both my clinical and personal experiences. Still, I was careful not to attribute the rapport solely to identity; the topic, participants' readiness to reflect, and the co-constructed nature of IPA all likely played a role.

This reflection cemented the value of researcher reflexivity and reminded me that rich data emerges not only from method, but from the relational space we create with participants, an insight I'll carry forward into future work.

Appendix 2: Ethics approval

University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO	Priam Juggernauth
CC	Dr Emma Karwatzki
FROM	Dr Rebecca Knight, Health, Science, Engineering and Technology ECDA Vice-Chair
DATE	26/04/2024

Protocol number:	**LMS/PGR/UH/05613**
Title of study:	Exploring the experience of compassionate leadership in clinical psychologists working in health and social care settings.

Your application for ethics approval has been accepted and approved with the following conditions by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

Dr Helen Eracleous, Clinical Psychologist, Hertfordshire Partnership NHS Trust

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is valid:

From: 26/04/2024

To: 30/04/2025

Appendix 3: Participant information sheet

University of Hertfordshire UH Ethics Committee

PARTICIPANT INFORMATION SHEET

Exploring the experience of compassionate leadership in clinical psychologists working in health and social care settings

Who am I?

My name is Priam Juggernauth (He/Him/His). I am in my final year of completing a Doctorate in Clinical Psychology (DCLINPSY) at the University of Hertfordshire.

Introduction

You are being invited to take part in my major research project on compassionate leadership. Before you decide to take part, it is important you understand what the study is, and what your involvement will include. Please read the following information carefully and discuss it with others if you wish. Do not hesitate to ask me anything that is not clear, or for further information you would like to help you decide to take part The University's regulation, UPR RE01, 'Studies Involving the Use of Human Participants' can be accessed via this link: https://www.herts.ac.uk/about-us/governance/university-policies-and-regulations-uprs/uprs

(after accessing this website, scroll down to Letter S where you will find the regulation)

What is the purpose of this study?

This study aims to explore compassionate leadership within clinical psychology, a concept referenced in the British Psychological Society's (BPS) leadership development framework (BPS, 2010) but not fully defined. Compassionate leadership, especially crucial during the pandemic, is rooted in the human instinct to care, and involves creating safe, supportive environments rather than eliminating threats. The study seeks to address the underrepresentation of clinical psychologists as leaders in healthcare, aligning the profession with modern leadership practices.

Do I have to take part?

Participation is voluntary, and you can withdraw at any time without consequence of any form. If you choose to participate, you will receive an information sheet and be asked to sign a consent form.

What is the inclusion criteria for this study?
All 4 criteria below must be met to take part in this study.

- A qualified clinical psychologist at band 7 (or health and social care or charity equivalent) or above.
- Self-identifying as having experience of enacting compassionate leadership.

- Self-identifying with compassionate leadership being important to their practice.
- Has worked in a health and social care setting within the last 12 months.

Why is there an inclusion criteria for this study?
The study focuses on participants who strongly align with the value of compassion, a key aspect of healthcare as emphasised within health and social care, the BPS, and the Health & Care Professions Council. While many clinical psychologists see themselves as compassionate, it is particularly important this study identifies those with a strong connection to enacting compassionate leadership to help provide richer insights.

Prospective participants will self-screen by reviewing a 16-item self-report compassionate leadership questionnaire that has been validated in a healthcare setting. The questionnaire will not be scored, but used as a tool to introduce the topic of compassionate leadership to help prospective participants decide if compassionate leadership is important to their practice and if they want to be interviewed regarding their experiences.

How long will my part in the study take?
Before the study, prospective participants will self-screen by spending a few minutes reviewing the 16-item self report compassionate leadership questionnaire. If they still want to participate in this study, they will then take part in a 60-80 minute interview to discuss their experiences of compassionate leadership.

What will happen to me if I take part?
Following the self-screening of the brief 16-item compassionate leadership questionnaire, if a prospective participant feels compassionate leadership is important to their practice and wants to participate in this study, they can consent to take part in the study and provide some basic details about themselves. Following this, the participant will be contacted to schedule a semi-structured interview.

What are the possible disadvantages, risks or side effects of taking part?

It is very unlikely that there will be any disadvantages or risks of taking part. Participants may choose to draw on emotive or sensitive issues in talking about compassionate leadership should they wish.

What are the possible benefits of taking part?

There are no immediate direct benefits, though participants may find this a thought-provoking topic. This research aims to contribute to leadership research and inform leadership interventions in clinical psychology, while also improving representation of clinical psychologists as healthcare leaders.

How will my taking part in this study be kept confidential?

Participants will be given a false name and their service will also be known in general terms, (e.g. "an adult service") when referring to in the research paper. A separate, secure tracker will link real names to false names for administrative purposes, such as withdrawal or data review, but this will not be part of the research paper.

What will happen to the data collected within this study?

All collected data, including the spreadsheet tracker, consent forms, transcripts, and interview recordings, will be stored securely on the University of Hertfordshire's Office 365 cloud drive, accessible only by the lead researcher and supervisor through password and multifactor authentication. The data will be deleted after the research is graded as a pass.

Will the data be required for use in further studies?

The data will not be used in any further studies.

Who has reviewed this study?

This study has been reviewed by the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority. The UH protocol number is LMS/PGR/UH/05613.

Who can I contact if I have any questions?

If you would like further information or would like to discuss any details personally, please get in touch with me by email at pj22aaj@herts.ac.uk. Alternatively, you may contact the principal supervisor, Dr Emma Karwatzki (Programme Director) at e.karwatzki@herts.ac.uk .

Although we hope it is not the case, if you have any complaints or concerns about how you have been approached or treated during this study, you may write to the University's Secretary and Registrar at the following address:

Secretary and Registrar

University of Hertfordshire

College Lane

Hatfield

Herts

AL10 9AB

Thank you very much for reading this information and giving consideration to taking part in this study.

Appendix 4: Consent form

University of Hertfordshire UH Ethics Committee

Consent Form EC3

Exploring the experience of compassionate leadership in clinical psychologists working in health and social care settings.

UH Protocol Number: LMS/PGR/UH/05613

If you agree, please initial in the box

1. I confirm that I have read the participant information sheet for this study. I have had the opportunity to consider the information around the aims, method, design, any follow up, ask questions and have had these answered satisfactorily.	
2. I understand what I'm required to do to participate in this study.	
3. I understand that any voice or video recording will be stored on university cloud-based storage which can only be accessed by multifactor authentication, university log in details, and a personal device password.	
4. I understand that any voice or video recording will be used to aid transcription of notes only, and the recordings will be deleted once they have served their purpose. I have also been given information on how information will be stored (in the participant information sheet).	
5. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.	
6. I understand that my input will remain confidential, and my personal information will be protected from being identified in the results of this study.	
7. I understand that the researcher may contact me when the study is completed to share the results with me, though my input will not personally identify me in the research.	
8. I understand that the information I generate will be used for a doctoral thesis and may be published and publicly available in a research journal and/or article, or other public repository.	

9. I agree to take part in this study.	
NEXT PAGE	

Please enter your role (Eg: Clinical Psychologist)	
Please enter your preferred name and any preferred pronouns if applicable (Eg: She, her, hers, he, him, his, they, them, theirs, ze, zir, zirs, xe, xem, xyrs, ey, em, eirs, per, pers, fae, faer, faers)	
There are 4 contextual questions below which are optional. They are being asked because they may inform ones view of what compassion is and how it is experienced, and could help in this research project.	
What is your ethnicity?	
What is your gender?	
What are your religious and/ or spiritual beliefs (if applicable)	
What is your approximate age group/ range?	
What is your email address (for contact to book the online interview)	
Are there dates or times you cannot meet? Or do you have any preferred dates or times you can meet? Please state if so.	

Name of participant	*Date*	*Signature*
Name of person taking consent	*Date*	*Signature*
xxxxxxxxxx, trainee clinical psychologist, university of Hertfordshire.		

Appendix 5: 16 item self-report compassionate leadership questionnaire (Sansó et al, 2022)

This has been validated in a healthcare setting. You do not need to complete or return this. It has been provided to help you reflect on enacting compassionate leadership and your onward participation in this study.

Question Number	**Indicate your agreement or disagreement with the following sentences regarding your behaviour when you lead your work team:**	**Completely Disagree**	**Disagree**	**Neither Agree or Disagree**	**Agree**	**Completely Agree**
1	I listen carefully when exploring problems.					
2	I pay close attention when listening.					
3	I am very attentive when a member of the team tells me about difficulties					
4	I give full attention when members of the team describe challenges they face.					
5	I am helpful in understanding the causes of difficulties the team faces.					
6	I do not impose my understanding of the causes of difficulties the team faces.					
7	I take time to understand carefully the causes of the problems.					
8	I work together with the team to come to an understanding of problems.					
9	I am genuinely warm and empathic.					
10	I am emotionally in touch with others' feelings when they are upset.					
11	I am sensitive to what others are feeling.					
12	I genuinely care about others' difficulties.					
13	I help people practically with problems they face.					
14	I take effective action to help others with the problems they face.					
15	I deal effectively with problems in order to help others.					
16	I am genuinely committed to making a difference by serving others.					

Appendix 6: Recruitment poster

CLINICAL PSYCHOLOGISTS NEEDED FOR RESEARCH INTO COMPASSIONATE LEADERSHIP

Seeking 12 Clinical Psychologists

Band 7 or above (or public sector equivalent)

Working in a public health and social care setting, third sector, or charity within the last 12 months

Identifies as a compassionate leader (after a 2 minute self-screening)

Willing to take part in a 60-80 minute interview on their experience of being a compassionate leader.

Improve leadership insight into clinical psychology from a range of clinical psychologists.

Research Aims: To investigate

- The experience enacting compassionate leadership, for example;
- organisational structure influencing compassionate leadership.
- the barriers and facilitators of compassionate leadership.
- ethical dilemmas
- culture and compassionate leadership.

Why?

- Clinical psychologists are underrepresented leaders in healthcare leadership research.
- Compassionate leadership is at the forefront of leadership post pandemic.
- Supporting the decolonisation of leadership concepts. and to be inclusive of the diverse settings clinical psychologists work in.

This research study has been approved by *The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority;* Protocol number **LMS/PGR/UH/05613**

University of Hertfordshire UH Ethics Committee

If you wish to participate or have questions, please contact me (Lead researcher, 3rd Year DClinPsy trainee), Priam Juggernauth (He/ Him/ His) at pj22aaj@herts.ac.uk

Appendix 7: Semi structured interview

Opening and Consent

- Confirm who is present.
- Remind participant that the interview is confidential and is recorded for transcription.
- Ask again for their consent to record, and reassure them they can withdraw any time.
- Ask: *"Are you happy to begin?"*

1. Motivation and Meaning/ Warm up

Main Question:

- *What motivated you to take part in this study on compassionate leadership?*

Prompts:

- Was there something about the topic that resonated with your own experiences?
- How does this topic relate to your current role or interests?

Main Question:

- *What does compassionate leadership mean to you?*
- *What skills or values do you draw on when enacting compassionate leadership?*

Prompts:

- What skills or values do you drawn on when enacting compassionate leadership?

Main Question:

- *What types of leadership tasks are you involved in?*/ day-to-day leadership responsibilities?

2. Experiences of Enacting Compassionate Leadership

Main Question:

- *Can you think of one or two standout experiences where you had to lead with compassion?*

Prompts:

- What was the situation?
- What made compassion leadership important in that moment?

Follow-up Questions:

- What were your thoughts and feelings at the time?
- Was your response conscious or instinctive?
- What the experience bring out in you (emotions or sensations)?

3. OPTIONAL- Dilemmas? Maybe depending on what comes up.

Main Question:

- *Do you ever experience dilemmas when leading compassionately?*

Prompts (try to use their examples, not theoretical ones):

- For example, balancing empathy with fairness or dealing with mistakes.
- What's does that feel like for you?

4. Systems and CL

Main Question:

- *How do you experience enacting compassionate leadership within your wider system — such as your organisation, hierarchy, or with patients?*

Prompts:

- Is it easier or harder?

Facilitators:

- *What helps or supports you to lead compassionately in your system?*

Barriers:

- *What gets in the way or makes it more difficult?*

Follow-up:

- What challenges have you faced? / How do these challenges affect you?
- How do you cope or recover from these experiences?

5. Social graces

Main Question:

- *Do your personal characteristics like age, gender, ethnicity, or culture, influence how you lead compassionately?*

Prompts:

- How do these factors shape your leadership style or how others respond to you?

Main Question:

- *Is being a compassionate leader a conscious process for you?*

Prompts:

- Can you talk me through that process?

6. Final reflections

Main Question:

- *What kinds of support/ resources do you drawn on to be able to lead compassionately?*

Main Question:

- *Is there anything else you'd like to share that we haven't covered?*

Appendix 8: Exploratory noting and experiential statements extracts

stories or when you connect to people on a human level, for example genuinely asking how things going and they say something difficult is going on, 'that sounds really hard', or this is going on, like 'Oh my God, that's amazing, well done'. So it's really it's not being a leader or somebody in a hierarchy, it's just one human to the next.	**Descriptive:** being a CL evokes a sense of care and human connection, viewing interactions as one human to another rather than hierarchical. **Linguistic:** "genuinely asking," "that sounds really hard," and "Oh my God, that's amazing" reflects emotional engagement and authenticity.	Column1 = transcript, Column 2 = exploratory notes, Column 3 = experiential statements Human centred seeks to understand peoples circumstances rather than be task orientated. (PP4, P10)
but I think what it engenders in me is a kind of responsibility of care. And I don't mean that in a negative way. I feel like that's a privilege given to me in that position, and so it's my responsibility to provide people with the best work environment for them to be their best selves, because that's when they, even when things are hard, they will feel like the work that they've done is meaningful.	**Conceptual:** CL is a relational and human-centric process, emphasising genuine care and recognition of personal stories and achievements.	
I guess I draw on attachment theory really for that because you know, if it's not seen, then it's as if it hasn't happened. So it bit like the child that doesn't have their responses mirrored, they never learn what that is. So I think it's important to recognise, to be seen, to be heard, to be genuinely seen by the others in hierarchies.	**Descriptive:** link to attachment theory, emphasising the importance of recognition and validation within hierarchical structures. **Linguistic:** "if it's not seen, then it's as if it hasn't happened" - recognition as fundamental to human connection.	Compassionate leaders recognise and value team members by making people feel seen and heard, bridging the gaps inherent in hierarchical systems. (PP4, P10)
You see this in the kind of anti-racism stuff as well, that if the dominant structure or person doesn't recognise and acknowledge, that's a thing, it's as if it hasn't happened, it's as if it's not a thing. So you devalue and you dismiss and you make invisible those experiences which leaves the person feeling anxious, shamed.	**Descriptive**: compares un-acknowledged events to anti-racism efforts, where ignoring or dismissing them leads to anxiety and shame. **Linguistic**: "devalue," "dismiss," and "make invisible" highlights how these actions invalidate others' experiences.	Psychological safety by recognising and validating others' experiences to prevent feelings of anxiety or shame, ensuring they are seen and heard (PP4, P10)

Researcher In this comparing to the first obviously very different situation, but both throwing out times where you had to enact compact compassion, or be a compassionate leader. But in this in this for in this situation, supporting her through XXXX, you didn't mention that you felt tired or frustrated in in this situation? Was it different?		Column1 = transcript, Column 2 = exploratory notes, Column 3 = experiential statements
xxxxx No, no, not tired, not frustrated. Sad. But with a very small amount of anxiousness that it would happen for her. Maybe apprehensive is better than anxious. I don't know, like, 'oh, my God, I really hope this happens for her'. That sort of thought feeling. I thought was compartmentalising good for her in her role working with children and parents, or actually, I remember my brain kind of trying to figure out 'What does she need and how? How can I have a conversation?' It's obviously something very sensitive for her to talk about. How can I have a conversation with her in a way that enables us to think about herself, given she's clearly trying not to feel, keep it professional, I think there's a construct about what professionalism is and isn't. Maybe do I trust this person, yeah, I think trust is key is a really big aspect of it. And I think compassion builds trust.	**Descriptive:** sadness and apprehension is distinguished from tiredness or frustration. **Conceptual:** Concern for staff member's outcome. **Conceptual:** cognitive process of strategising the conversation. **Linguistic:** Rhetorical questions shows active problem-solving approach. **Descriptive:** balancing sensitivity with professional boundaries to address emotional and practical needs. **Descriptive:** Highlighting professional constructs and querying if it includes relational dynamics. **Descriptive:** Trust Is central to compassionate leadership.	Deep empathy and concern for the staff member's personal and professional situation. (PP5, P18) Balancing her anxiety and care for staff with professional support to build trust in the relationship. (PP5, P18)
Researcher Yeah. And in. In either of those examples. Were there any sort of dilemmas that you that you faced when being a compassionate leader?		

Participant and page no. clearly linked to experiential statement and relevant transcript section in transcript for easy quote location

So then you mentioned earlier, I'm thinking of dilemmas, something about you can be compassionate but not to the point where, well I can't remember the exact word you used. You didn't say taking advantage of, but you were kind of kind of going down that line. So I wondered if you could kind of tell me about some of the dilemmas that you face maybe being compassionate leader?		Column1 = transcript, Column 2 = exploratory notes, Column 3 = experiential statements
A different participant xxxxxx	Participant and page no. clearly linked to experiential statement and relevant transcript section in transcript for easy quote location	
Yeah. Yeah, I think it can be a tricky position to be in and I feel like this is something that would probably continue to come up where you know you want to be compassionate, but also be clear about what may be expected in a role or in a team, or if there are certain aims. Even things like, like, flexible working. So I think it's sometimes when you want to support someone and be compassionate, but not kind of give the message that someone is free to do whatever they want and not remembering that they are an employee, that they work in the NHS. It hasn't happened so far with myself, but I can imagine it and it depends on who the other colleague is, and it comes back to trust. If I gave someone autonomy and trust to, manage their own time and take back time when they went over, they could just let me know. But, then if I suddenly found out that they were off for the whole day, or they were somewhere else, I think that would break that trust. So how does that conversation happen in a compassionate way, like 'OK this is what happened, so why did it happen? And then what did they do?'.	**Linguistic**: "Tricky position" and "continue to come up" imply ongoing challenges in balancing these elements. **Conceptual**: Navigating the balance between compassion and role expectations is a recurrent dilemma. **Descriptive**: specific situations, like flexible working, where compassion may conflict with professional expectations. **Linguistic**: "Trust" is central to compassionate leadership. **Conceptual**: Compassionate leadership involves providing autonomy, but this requires trust between leader and employee, especially in managing time and workload. **Descriptive**: explores the potential breakdown of trust and the challenge of having compassionate conversations when expectations aren't met. **Conceptual**: Issues can be addressed compassionately via an inquisitive	Compassion can be minsunderstood, not being seen as nice but needing to manage expectations. (PP8, P19) Enacting compassionate leadership means maintaining flexibility with professional boundaries. (PP8, P19) Compassionate leaders assume trust from the start but are wary of there being potential for issues. (PP8, P19) Compassionate leadership must navigate challenging conversations when trust is

Appendix 9: Word list of a participant's experiential statements

Participant 1- Part word list of experiential statements that corroborate statement to page number

46. challenging momentum to encourage reflection, which she requires bravery. Halting a process, courage to disagree. (PP1, P15)
47. compassionate leadership includes humility, acknowledging personal limitations. (PP1, P16)
48. Good enough: Compassionate leadership as a counterbalance to perfectionism, which can lead to burnout. (PP1, P16)
49. self-compassion is essential to sustaining her ability to lead compassionately. (PP1, P16)
50. Self-care maintains compassionate leadership. (PP1, P16)
51. Good enough: self-forgiveness as a key part of compassionate leadership, enabling her to model humility. (PP1, P16)
52. practicing self-compassion is difficult and is a continual effort in her leadership journey. (PP1, P17)
53. Support by supervision is important when feeling anxious and overwhelmed. (PP1, P17)
54. Challenge of compassionate leadership and wanting to include everyone given time constraints and feeling uncomfortable. (PP1, P18)
55. Compassionate leadership advocates advocate for a slower, more thoughtful approach within a system that prioritises speed over reflection. (PP1, P18)
56. High energy demands of empathetic leadership, particularly in staying aware of others' perspectives. (PP1, P18)
57. Compassionate leadership is easier when there are helpful role models/ experience of not having CL. (PP1, P19)
58. compassionate approach often conflicts with the fast-paced demands of her role, causing her anxiety. (PP1, P19)
59. Compassionate leadership is uncomfortable in complex cases, as it requires deeper empathy for challenging situations. (PP1, P19)
60. Leading compassionate feels more feasible when there is the absence of policy-driven restrictions. (PP1, P20)
61. Being compassionate created self doubt and anxiety in the short run, but led to long term team benefits (PP1, P21)

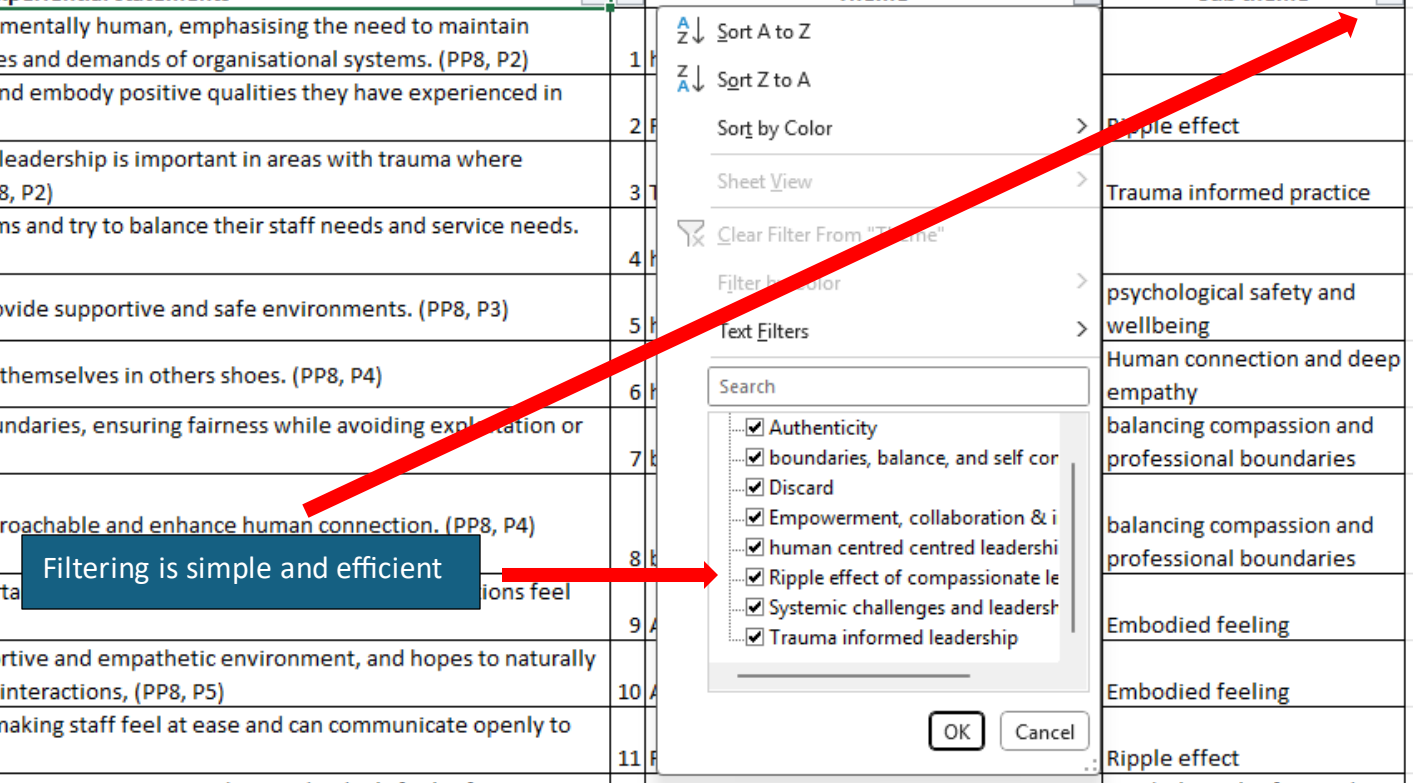
Appendix 10: Linking experiential statements to themes and sub themes via excel

Participant 2 experiential statements		Themes	Sub themes
compassionate leadership aligns well with her personal and professional values which enhances both practice and personal growth. (PP2, P1)	1	Innate alignment with values and ethics	Leadership rooted in values
Emphasises the need for self-reflection to retain core values during career transitions. (PP2, P2)	2	Innate alignment with values and ethics	Leadership rooted in values
being sensitive to others' experiences and fostering a shared understanding. (PP2, P2)	3	Emotional connection and challenge	Empathetic action
Being curious about others experiences and being proactive in supporting change is essential. (PP2, P2)	4	Emotional connection and challenge	Empathetic action
Compassion's potential misunderstanding as a weakness while highlighting its importance in leadership. (PP2, P2)			
Compassionate leadership as a courageous and responsive practice and not simply listening. (PP2, P3)			Courage to lead
Compassionate leadership is client centred, and ethical regardless of the distance the leader from the client. (PP2, P3)			Ethical leadership practice
Compassionate leadership is applicable to all tasks ensuring staff satisfaction. (PP2, P4)	8	Innate alignment with values and ethics	Ethical leadership practice
respect and a deep sense, genuine desire to help. (PP2, P4)	9	Innate alignment with values and ethics	Ethical leadership practice
compassionate leadership is more a natural style that provides better outcomes than strict approaches. (PP2, P5)	10	Innate alignment with values and ethics	natural element of compassionate leadership
The centrality of care and respect in her leadership values. (PP2, P5)	11	Innate alignment with values and ethics	Leadership rooted in values
Courageous and daring leadership while also staying focused amid external pressures (PP2, P5)	12	Courageous and intentional action	resilience amidst challenges
Slow things down rather than firefighting. (PP2, P6)	13	Courageous and intentional action	resilience amidst challenges
Focus is on empowering others rather than impose quick is vital for her leadership effectiveness. (PP2, P6)	14	Courageous and intentional action	Empowering others

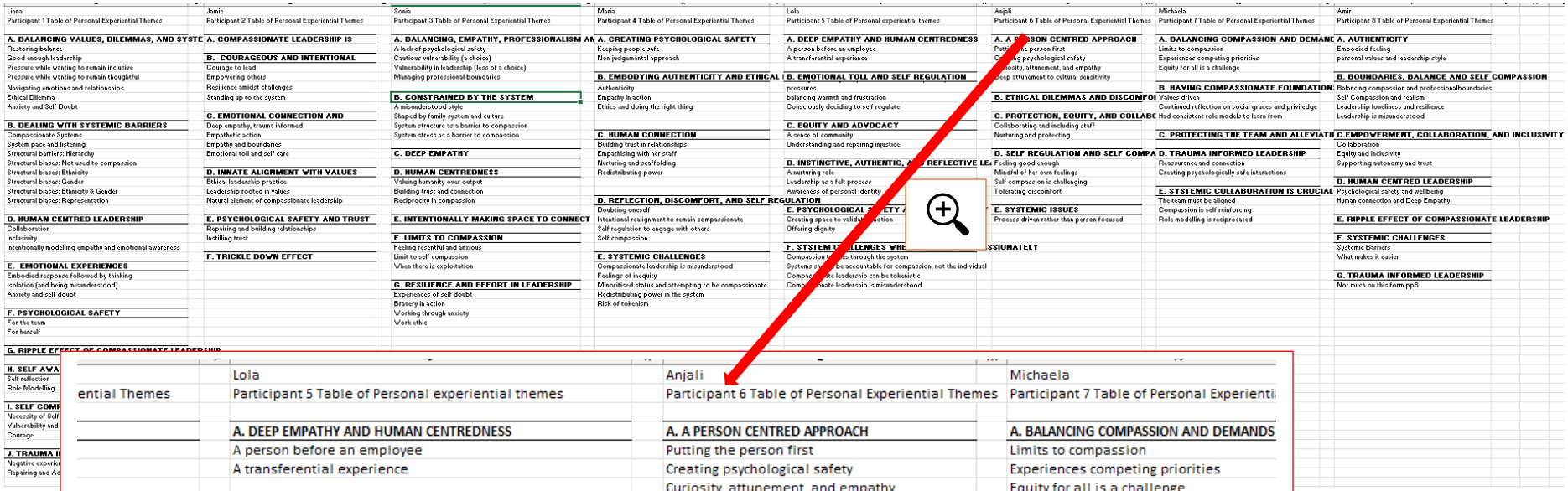
Excel convenience: Each statement has the participant number and page number, lined up with the theme.

Very simple to go back to the transcript and find the quote.

PP8 - Experiential statements		Theme	Sub theme
Enacting compassionate leadership is fundamentally human, emphasising the need to maintain empathy and humanity despite the pressures and demands of organisational systems. (PP8, P2)	1		
Compassionate leaders strive to replicate and embody positive qualities they have experienced in receiving leadership. (PP8, P2)	2		Ripple effect
Trauma informed- Enacting compassionate leadership is important in areas with trauma where empathy and understanding are crucial. (PP8, P2)	3		Trauma informed practice
Compassionate leaders humanise their teams and try to balance their staff needs and service needs. (PP8, P3)	4		
Enacting compassionate leadership is to provide supportive and safe environments. (PP8, P3)	5		psychological safety and wellbeing
Deep empathy, Compassionate leaders put themselves in others shoes. (PP8, P4)	6		Human connection and deep empathy
challenge of balancing compassion with boundaries, ensuring fairness while avoiding exploitation or undermining professionalism. (PP8, P4)	7		balancing compassion and professional boundaries
Compassionate leadership means to be approachable and enhance human connection. (PP8, P4)	8		balancing compassion and professional boundaries
Humanising and human connection is importa ions feel warm and appreciating staff. (PP8, P5)	9		Embodied feeling
Consciously thinking about creating a supportive and empathetic environment, and hopes to naturally model compassion and warmth through his interactions, (PP8, P5)	10		Embodied feeling
Ripple effect of bringing people together, making staff feel at ease and can communicate openly to enhance team dynamics. (PP8, P5/6)	11		Ripple effect
Seeks to lead by example, fostering a transparent environment where individuals feel safe to voice concerns, ultimately strengthening collective team unity. (PP8, P6)	12	human centred centred leadership	psychological safety and wellbeing
Compassionate leaders hold in mind equity and inclusivity for staff. (PP8, P7)	13	Empowerment, collaboration & inclusivity	equity and inclusivity
Enacting CL demonstrates empathy and practical support for supervisees by listening to their challenges and making necessary adjustments to their roles. (PP8, P8)	14	Discard	
Deeply empathetic, CLs put themselves in their staff shoes, and have learn from personal experiences to be flexible in approach to create a supportive environment. (PP8, P8)	15	human centred centred leadership	Human connection and deep empathy
Compassionate leadership involves navigating competing priorities, requiring balance and			



Appendix 11: Master PETS table on excel of all participants



	Lola	Anjali	Michaela
ential Themes	Participant 5 Table of Personal experiential themes	Participant 6 Table of Personal Experiential Themes	Participant 7 Table of Personal Experienti
	A. DEEP EMPATHY AND HUMAN CENTREDNESS	A. A PERSON CENTRED APPROACH	A. BALANCING COMPASSION AND DEMANDS
	A person before an employee	Putting the person first	Limits to compassion
	A transferential experience	Creating psychological safety	Experiences competing priorities
		Curiosity, attunement, and empathy	Equity for all is a challenge
ICAL RESPONSBILITY	B. EMOTIONAL TOLL AND SELF REGULATION	Deep attunement to cultural sensitivity	
	pressures		B. HAVING COMPASSIONATE FOUNDATIONS
	balancing warmth and frustration	B. ETHICAL DILEMMAS AND DISCOMFORT	Values driven
	Consciously deciding to self regulate		Continued reflection on social graces and
		C. PROTECTION, EQUITY, AND COLLABORATION	Had consistent role models to learn from
	C. EQUITY AND ADVOCACY	Collaborating and including staff	
	A sense of community	Nurturing and protecting	C. PROTECTING THE TEAM AND ALLEVIATING
	Understanding and repairing injustice		
		D. SELF REGULATION AND SELF COMPASSION	D. TRAUMA INFORMED LEADERSHIP
	D. INSTINCTIVE, AUTHENTIC, AND REFLECTIVE LEADERSHIP	Feeling good enough	Reassurance and connection
	A nurturing role	Mindful of her own feelings	Creating psychologically safe interactions
	Leadership as a felt process	Self compassion is challenging	
	Awareness of personal identity	Tolerating discomfort	E. SYSTEMIC COLLABORATION IS CRUCIAL
REGULATION			The team must be aligned
	E. PSYCHOLOGICAL SAFETY AND VULNERABILTIY	E. SYSTEMIC ISSUES	Compassion is self reinforcing
mpassionate	Creating space to validate emotion	Process driven rather than person focused	Role modelling is reciprocated
	Offering dignity		
	F. SYSTEM CHALLENGES WHEN WORKING COMPASSIONATELY		
	Compassion trickles through the system		
lerstood	Systems should be accountable for compassion, not the individual		
	Compassionate leadership can be tokenistic		
be compassionate	Compassionate leadership is misunderstood		

Appendix 12: CASP Quality appraisal of thesis research

Criteria	Appraisal
Was there a clear statement of the aims of the research?	Yes. The study clearly aimed to explore the enactment of compassionate leadership, specifically from the perspective of those offering compassion rather than those receiving it. It also sought to examine how systemic factors intersect with the practice of compassionate leadership.
Is a qualitative methodology appropriate?	Yes. A qualitative design was appropriate, given the focus on participants' meaning-making processes. The study employed IPA, suitable for its exploration of subjective experience. A homogeneous sample was selected based on professional role, with participants self-identifying as compassionate leaders, further justifying the use of IPA.
Was the research design appropriate to address the aims of the research?	Yes. The research design was well aligned with the study aims. Purposive sampling was employed, supplemented by a self-screening tool that enabled participants to assess their alignment with criteria for compassionate leadership. This ensured relevance and depth in the data collected as participants were self-motivated.
Was the recruitment strategy appropriate to the aims of the research?	Yes. The recruitment strategy was thoughtfully constructed, with consideration given to encouraging participation from individuals from the global majority, and to broader demographic diversity including age and leadership experience. This reflects a mindful approach to inclusivity in leadership research.
Was the data collected in a way that addressed the research issue?	Yes. Data were collected through online semi-structured interviews, which were audio-recorded, transcribed verbatim, and stored securely on password-protected servers. Interview questions were iteratively refined with input from the research team to ensure a focus on eliciting meaning, rather than solely descriptive accounts.
Has the relationship between researcher and participants been adequately considered?	Yes. The researcher engaged in ongoing reflexivity through a reflective diary and regular research supervision. Awareness of the double hermeneutic central to IPA was demonstrated, acknowledging the researcher's interpretative role in making sense of participants' own sense-making.
Have ethical issues been taken into consideration?	Yes. Ethical approval was obtained from the university with no conditions. Participants were provided with an information sheet, informed of their right to withdraw, and assured of anonymity and confidentiality throughout the research process.
Was the data analysis sufficiently rigorous?	Yes. A systematic and transparent analytic process was followed, adhering to the seven steps of IPA. This included exploratory noting, the development of experiential statements, clustering, and the identification of

	both Personal and Group Experiential Themes. The primary supervisor reviewed sections of the analysis, with broad agreement on the interpretations made.
Is there a clear statement of findings?	Yes. The findings were clearly presented, with six Group Experiential Themes (GETs) identified and substantiated through rich, illustrative data extracts. These themes captured both shared and nuanced aspects of participants' experiences.
How valuable is the research?	The research offers valuable insights from a sample of eight clinical psychologists on the enactment of compassionate leadership within healthcare systems. It contributes meaningfully to contemporary leadership discourse and provides practical recommendations for the development of compassionate leadership practices in clinical psychology and system-level leadership initiatives.